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THE DISTRIBUTION OF HEALTH CARE IN A JUST SOCIETY

Salsberry, Pamela Jayne, Ph.D.
The Ohio State University, 1987

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THE DISTRIBUTION OF HEALTH CARE IN A JUST SOCIETY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By

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* * * * *

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ACKNOWLEDGMENTS

I wish to thank my adviser for his thoughtful comments and guidance throughout this project and the members of my committee for their suggestions and careful review. I also want to acknowledge and thank my husband for his patience and understanding during this endeavor, and my mother for her continual love and support.
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PUBLICATIONS


FIELDS OF STUDY

Area of Specialization: Ethics and applied ethics

Area of Competence: Social and Political Theory, and Theory Development (Nursing)
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CHAPTER I

INTRODUCTION AND OVERVIEW

Our society continues to debate the extent to which the government should guarantee a broad range of health care services for all of its citizens. With the demand for coverage of catastrophic illnesses being made in a time of budget deficits this debate has intensified. Traditionally, such services have been justified by appealing to rights, to utilitarian considerations, or to the inhumanity of not providing such services. The problem with these approaches is that the arguments fail on their own to justify the redistribution required to achieve their outcome. Others have argued, e.g., the libertarian and free market advocates, from a particular theory of rights that society (i.e., the government) has no obligation to provide health care or other services. They seem to dismiss, without serious consideration, the view that the same reasons for providing police protection can be extended to providing at least some health care services.

But this controversy is not new. It is only one version of a longstanding dispute amongst political theorists.
as to how the resources within a society ought to be distributed. It is a classic problem that has received new attention since John Rawls' *A Theory of Justice*. In this project I consider the weaknesses of recent theories given for a particular health care distribution and argue that the fundamental disagreement is about the correct theory of distribution for a just society. I examine and criticize recent theories of justice and develop an alternative.

There is one further and quite different area of disagreement among individuals who discuss the health care delivery system. That is: what health care services should be guaranteed to all? One would think that those who argue for a free market approach would place few or no restrictions on the services to be offered, allowing the market to prevail. However, many of these individuals believe that abortion and other experimental reproductive services, e.g., in vitro fertilization, should not be available. Many who have endorsed the rights argument disagree on whether there is a right to such services as breast augmentations, tummy tucks, and other cosmetic surgeries. Part of this disagreement, and at times confusion, is traceable to uncertainty about what is health and disease. Many think that any service provided by a health care professional falls within the domain of disease treatment, and therefore should be offered.
Thus, not only is there disagreement about what is entailed by a theory of distributive justice, there is no consensus about how to limit or identify services which should be included within the scope of benefits. This project addresses these two major areas by developing a theory of distributive justice and offering an analysis of health and disease. The pattern of health care services required by the results of these analyses is then examined.

The scope of this project is to address one relatively small question having to do with the rightness or wrongness of distributional patterns in societies which have moderately scarce resources. Many following Hume have argued that considerations of justice apply only when persons find themselves under conditions of moderately scarce goods, limited generosity, rough equality of capacities and aptitudes, and interdependence. Even though I disagree with Hume on this point, for practical reasons, I will argue within these conditions. However, this should not be interpreted as an endorsement for Hume's claim that considerations of justice apply only under these conditions.

In developing and defending a theory of distributive justice I reject the libertarian's position with respect to entitlements and argue for a conception of distributive justice similar to the ones discussed by John Rawls (1971) and Ronald Dworkin (1981b). Basically, Rawls claims that the
allocation of resources (primary social goods) ought to make the worst-off person the best he can be. Dworkin, on the other hand, states that justice should be seen as equality of resources and requires that all individuals have their fair share of society's resources, taking into consideration fundamental inequalities of life, i.e., differences in natural endowments such as talents and abilities, and differences in health status. I argue that justice requires a division of social goods that results in each individual receiving enough goods and services to allow for the achievement of a satisfactory welfare level, consistent with the most extensive equal freedom to choose and pursue one's life plan, compatible with a similar freedom for all.

I also consider the difficult question of 'What ought to count as a health care service?' The actual services required by justice will depend first upon which services turn out to be members of this class. I argue that these services are limited to services which treat, care for, or cure disease, or promote or maintain health. Disease is defined as functioning below some central range of the statistical distribution for that ability in corresponding parts in an appropriate reference class. Health is the physiological ability of an organism to respond to its environment in a species-typical manner that allows it to
survive and meet its basic needs. It is to this set of services that the principle of justice applies.

Finally, once there is a theory of distributive justice to build upon, and an idea of what services should be included I consider what distributional pattern and services are entailed by these theories. I am most concerned with answering the question, 'What health care services will be provided by a fair or just society and to whom?' I argue, based upon the satisfactory welfare achievement principle (SWAP), for a distribution of health care services quite different from the present system. SWAP requires access to basic care for everyone, but does not provide a justification for the treatment of other diseases that are presently being treated (e.g., most cases of lung cancer). It should be clear to the reader that for the purposes of this discussion I have limited the question to considerations of distributive justice, but that other services may be morally required, justified by arguments for charity or beneficence, or from a principle of rectification.

In the final section, I discuss the implications that such a theory of justice would have on the health care policy decisions of a society.
CHAPTER II
WHY A THEORY OF DISTRIBUTION IS NEEDED

Introduction

The political left has long been associated with policies that expand welfare programs and guarantee access to a variety of health care services. Individuals attempting to justify these policies have used several different approaches to demonstrate why such programs are required. A review of their justifications however reveal that most if not all are a variation on two basic arguments. One of these arguments is that we have an obligation or duty to provide a decent minimum level of health care to all people because we have a general obligation to respect persons qua persons. Others argue for a slightly altered version of this approach, that it is inhumane not to provide services when the cost to others is small. These arguments rely upon Kantian intuitions that we should treat persons as ends, never as a means and they have been used to defend government sponsored health insurance programs like Medicare and Medicaid (see Stevens and Stevens, especially chapters 1 and 2, 1974). The claim is that health care benefits need to be available to all because it is inhumane not to provide basic health care to those in need, at least if a society can do
so without sacrificing something else of great moral significance. Thus, such social programs as Medicaid or Medicare are necessary because they meet this need.

The second argument claims that government involvement is justified because people have a positive right to health care, and since government must protect rights it has a role in health care distribution. This argument will work only if it can be shown that there is a positive right to health care and that government has a legitimate role in rights protection.

These arguments have not gone unchallenged. Those on the political right have argued from a theory based upon individual liberty and property rights, that the government has no role in the management or distribution of health care services. They argue that taxes needed to support health care services for the poor unjustly infringe on an individual's right to decide what shall happen with, and to, one's property. I will show that this libertarian theory, even given their theory of individual liberty, has failed to recognize that there are good reasons to have the government in the business of managing and distributing at least some limited number of health care services, based upon self-interest and the desire to protect oneself and one's family from injury or disease.
However, there are deep problems in both of these approaches. The rights and decency arguments fail on their own to justify the redistribution required. I will show these arguments must be embedded within a broader theory of distributive justice. Recent approaches have almost solely relied upon the social-contract theory discussed by Rawls. To fully evaluate these arguments a more thorough analysis of Rawlsian justice must be completed. Moreover, just as the rights and decency arguments require a grounding in a theory of justice, so too does the libertarian argument against health care. Ultimately the argument against providing health care services will depend upon the soundness of this theory of justice. This chapter considers recent approaches that answer the question: 'what health care services should be provided by a just society and to whom?'; the next chapter examines the grounding of these arguments.

Providing health care as the decent thing to do

Consider the following problem. Suppose there is a society in which there are two classes—the very poor and the very rich. The very rich go about their business without interacting with the poor (i.e., they do not take away resources from the very poor, but neither do they extend education or job opportunities to this group). Moreover, the very rich live in luxury, with numerous homes, cars, etc;
while for the most part the very poor live on the streets, have very little food, and frequently die from starvation. Such treatment (or noninterference and nontreatment) seems to many to be grossly at odds with the notion of respecting persons. If the very rich permit the very poor to starve when they could provide assistance without serious harm to themselves, there is a violation of this respect for persons. It would seem that part of respecting persons qua persons is recognizing their suffering and providing assistance to reduce this suffering whenever possible.

The argument for this claim is the following: 1) if one can prevent some suffering or harm and the cost of that assistance is small, then one ought to do it. This premise is defended either with utilitarian arguments (overall social utility is highest when this principle is followed) or deontological reasons (reduction of suffering is a duty). 2) Several services prevent or reduce harm (e.g., assistance with food, shelter). 3) Therefore, these services ought to be provided. (1) Thus, (in the above example) there is an obligation to help others (giving food) when that assistance does not cause serious harm to the helper.

Now consider a person in need of a health care service. Many people have argued that we ought to provide health care services (at least some minimum) to all persons because it is the decent or right thing to do. Persons who
find themselves in need of a health care service (for example, an appendectomy) should receive it regardless of their ability to pay, because it is inhumane not to provide this service. This claim rests upon the same argument used to defend providing food and housing; that is, that we should provide the service, or that we have an obligation to help others, when that assistance does not cause us harm.

However, even if one believes there is an obligation to help, it does not follow directly that a tax is justified in order to achieve this end or that the government should be in the business of overseeing this distribution. Thus, if this is the argument that is to justify government involvement in the distribution of the benefits and burdens of a health care system, it is inadequate. It is quite possible to accept the first part of the claim (i.e., we, individually or even collectively, have an obligation to provide health care services because it is the decent thing to do), yet deny there is any justification for the government to be involved in providing these services.

In particular this argument cannot convince the unbeliever, the libertarian, that government involvement is justified. In Anarchy, State, and Utopia, Nozick (1974) argues:

- a minimal state limited to the narrow functions of protection against force, theft, fraud,
enforcements of contracts, and so on, is justified: that any more extensive state will violate persons' rights not to be forced to do certain things, and is unjustified (p. ix).

Nozick does not think the state has any role in providing services other than protection for its citizens. Consider what Nozick says about medical care:

So it is society that, somehow, is to arrange things so that the doctor, in pursuing his own goals, allocates according to need; for example, the society pays him to do this. But why must the society do this? (Should they do it for barbering as well?) Presumably, because medical care is important, people need it very much. This is true of food as well, though farming does not have an internal goal that refers to other people in the way doctoring does. When the layers of Williams' argument are peeled away, what we arrive at is the claim that society (that is, each of us acting together in some organized fashion) should make provision for the important needs of all of its members (p.234-235).

Nozick goes further and holds that coercion of the physician to deliver his services in a way he does not choose, or coercion of others to take money to pay for such services, violates rights. Other arguments based upon equality, or duties to help others, will not be enough to justify a redistribution of wealth. Nozick can accept "the duty to help others principle", yet deny that a tax is justified.

It would seem then that Nozick's approach to the delivery of health care services would be the following: persons desiring or needing services should purchase them from the appropriate source. Those unable to pay for the service
would either do without or be placed in the position of receiving benefits due to others’ beneficence.

Allen Buchanan (1984) uses an approach similar to the decency arguments in his attempts to show that a decent minimum of health care should be provided to all persons. He offers a pluralistic strategy which he believes is sufficient to do the work of an alleged universal right to a decent minimum of health care. He argues in this way because he believes there is no universal right to health care. His strategy relies upon four different arguments: one for special rights, one for the prevention of harm, and two for enforced beneficence. The arguments for enforced beneficence rely upon the reasoning discussed above. That is, we ought to give to charities because it is recognizing the needs of others and by so doing we are respecting persons and/or doing the decent thing.

Buchanan’s enforced beneficence arguments are as follows. He assumes that there is a basic moral obligation of charity and beneficence to those in need. The first argument is:

1. Given the importance of health, providing a decent minimum for all will be a more important form of beneficence than various charitable acts.
2. To provide a decent minimum for all, there needs to be widespread collective involvement.
3. Individuals reason that their personal contribution does not matter, because if enough people give to achieve the decent minimum, then my contribution is not needed.
4. Therefore, enforced beneficence is necessary.
The second argument for enforced beneficence is similar to the above argument except that premise three is changed to reflect concerns that since I am not assured of others giving, I will not give. Thus, enforced beneficence is needed to assure that all will give and avoid what is frequently termed the free-rider problem. The result of both is that enforced beneficence is required to achieve the more important form of beneficence.

The other arguments given by Buchanan attempt to establish obligations to provide health care services based upon special circumstances and that some services are required for the protection of the public good. The first of these arguments relies upon special circumstances to establish obligations. These circumstances are 1) when individuals have been harmed because of unjust treatment in the past, e.g., blacks, native Americans, are entitled to health care services to rectify past injustices; 2) because of specific actions of identifiable individuals; or 3) individuals who have sacrificed their health while in the service of society in general deserve health care treatment for these injuries. The other argument that Buchanan gives is based upon a notion of protecting the "public's health". Certain services like immunizations and sanitation are required if widespread disease is to be prevented.
These final two arguments are successful in establishing obligations to provide a few health care services to a limited number of people. Buchanan’s crucial arguments however are the ones of enforced beneficence and the success of his approach depends upon how well these enforced beneficence arguments work. These arguments are based on the assumption that there is a moral obligation of charity or beneficence to those in need. It is because of this obligation that we must provide at least some health care services.

In a society that has the resources and technical knowledge to improve health or at least to ameliorate important health defects, the application of this requirement of beneficence includes the provision of resources for at least certain forms of health care. If we are sincere, we will be concerned with the efficacy of our charitable or beneficent impulses (Buchanan, 1984, p. 69).

Buchanan’s argument is simply that we should provide health care services because we have an obligation to help those in need and if we are sincere about this we will use coercion to enforce the obligation. His arguments fare slightly better than the decency arguments because he justifies the need for a tax to achieve the goal. That is, enforced beneficence (a tax) is required to eliminate the free-rider problem. However Buchanan’s arguments will not be persuasive to the libertarian since the arguments ultimately depend upon an obligation (based in a notion of respecting persons) to
help others that overrides one's right to property. Because of this, Buchanan's pluralistic approach will fail in its effort to justify a redistribution of services that guarantees a minimal level of services to all.

In summary, the duty to help others argument fails to justify the redistribution necessary to finance health care services for the poor and fails to justify a legitimate role for government in the provision of these services. Buchanan gives us reasons for why we must ensure giving, but his reasons ultimately depend upon one accepting the claim that we have an obligation to help others. Neither of these approaches are successful in establishing an obligation to help nor will they convince the libertarian that we should override property rights to ensure that help is available to those in need. However there is a second type of argument given to justify a broad range of services to the poor based upon a positive right to health care. If there is such a positive right, then we have a promising argument to convince the libertarian, to justify the redistribution that is necessary, and for a governmental role in the management and distribution of health care. The next section considers the arguments given to show that there is a positive right to health care.
The right to health care

The arguments given to demonstrate that there is a positive right to health care are offered as justification for equal access to at least some minimal number of services and to prove that the government has a role in the distribution of both the benefits and the burden of paying for these services. Since it is generally agreed that one of the legitimate functions of government is protection of rights, and that government has the power to impose reasonable taxes for the protection of these rights; then if there is a positive right to health care, the government is justified in imposing taxes to protect this right. This approach seems to be much more promising than the previous argument. The crucial question is whether there is such a positive right to health care and if this is established what services does this right guarantee. The focus here is on the first part of the question, 'is there a positive right to health care and how can we make sense of such a claim?' By claiming that someone has a right to health care I mean that if X has a right to health care, then X is entitled to these services. And if it is a valid rights-claim then it may be backed by sanctions to guarantee compliance. The claim that X has a right to health care is not equivalent to saying that the provision of health care would be a good thing, or even the desirable thing, it is a much stronger claim than
these. Thus, if we can establish that X has a right to health care, we will have a justification for the required redistribution to finance these services.

Many philosophers (Bell 1979; Buchanan 1984; Daniels 1979, 1981, 1983, 1985; Fried 1981; Green 1976, 1983; Outka 1974) have argued that all people ought to have access to a decent minimum of health care services because they have a right to these services. They use two primary approaches to justify this right to health care: natural rights arguments; and arguments based in a particular theory of justice. I will consider each approach briefly and give reasons why neither of these approaches is adequate. The grounding of a right to health care within a natural rights framework has been argued since at least the French revolution (McCullough, see pages p. 56-57). The eighteenth-century French revolutionary councils claimed that the right to health care was a natural right and something to which each human was entitled simply in virtue of being human. If one was sick and in need of treatment, then he ought to receive treatment. The second approach, arguments based in a particular theory of justice, have recently emerged following Rawls' *A Theory of Justice*. Many attempts have been made to take the Rawlsian theory of justice and show that a right to health care must be included as part of this theory.
The first approach based within a natural rights tradition can be easily dismissed. To claim that there is a right to health care is to say that one is entitled to services and not simply to noninterference. It is difficult to understand on what interpretation health care could be considered a natural right. Certainly not on recently accepted interpretations, e.g., Hart's. Hart puts it this way:

This right is one which all men have if they are capable of choice; they have it qua men and not only if they are members of some society or stand in some special relation to each other. Furthermore, (a) right is natural if it is not a right which is derived from positive law or social institutions (Hart, 1979, p.15).

Christman (1986) has revised this somewhat:

A right is a natural right if its possession is justified only with reference to a certain set of natural attributes of persons—that is, without reference to social conventions, legal institutions, or other special relationships within or among groups of persons (p. 158).

On these interpretations health care is not a natural right. As I will show in a later chapter, if health care is a right at all, it is because of special relationships among persons in a social setting, not because of any natural attribute of persons. The natural rights argument is inadequate to justify the redistribution required by the strong rights claim.

The second approach to this problem has been to ground the rights claim within a theory of justice. Outka argues
that all people should have equal access to health care because justice requires this (2). Nora Bell, Norman Daniels, and Ronald Green discuss a right to health care within the framework of a just society as described by John Rawls, in *A Theory of Justice* (1971). I will focus on two of the more detailed and thought-provoking discussions given recently by Daniels and Green, and discuss why I believe these to be inadequate as stated. Part of the reason for working through these approaches is to demonstrate that the crucial issues are answered by the theory of distributive justice and not the claim that there is a right to health care.

Green and Daniels argue that the claim that there is a right to health care can be given both a meaning and a foundation within a Rawlsian framework. This framework consists of two principles of justice (chosen under a veil of ignorance in the original position) which attempts to derive a system or an arrangement of institutions which permit a fair distribution of primary social goods. Rawls' primary social goods include "things that every rational man is presumed to want, i.e., rights and liberties, power and opportunity, income and wealth, and self-respect" (Rawls, 1971 p. 62). Norman Daniels' (1979, 1981, 1983, 1985) basic task is to demonstrate why health care is special so that we can figure out what kind of social good health care really
is. It needs to be pointed out that Rawls does not include health or health care within the primary social goods. Both Daniels and Ronald Green (1976, 1983) address the issue of whether health or health care services can be considered a primary social good in the Rawlsian sense and thus a good that the principles of justice would apply to. Their answers are different. Green argues that health care is equal with the basic liberties, while Daniels argues that health care is a means to achieving equal opportunity.

Green (1983) argues that the Rawlsian theory of justice provides an acceptable framework for discussing the right to health care, and that within Rawls' theory, health care should be treated on par with the basic civil liberties. Green believes justice requires that every individual has a right to equal access to the highest quality care and health programs that a society can afford. Access to health care may be compromised only to establish these services more firmly; that is, a limitation is justified only in cases where this is required to extend and improve the quality of these services.

Health status and access to health care play a role of assessing the overall justice of a society similar to that played by the economic condition of the least favored group in a Rawlsian approach to assessing the economic justice of a society. Along with the basic civil liberties, health and health care provision provide the key indices of social-moral progress (Green, 1983, p. 379).
Thus an additional criterion to judge the fairness of a society will be the access its members have to health care services.

Green claims that other social investments will continue because of their relationship with health and health care. Housing, education, and nutrition programs all directly affect the health of the population; thus funds would be diverted to these programs.

One of the major concerns with this approach is the trade-offs that are required if health care is viewed as a primary social good. Green argues that limits can be placed on health care services, just as limits can be placed on the civil liberties.

...it is useful to see clearly what is involved in a commitment to treat health care on par with the basic (civil) liberties. Such a commitment does not mean that life must always be maintained, pain alleviated or health restored—any more than a commitment to the civil liberties means that individual freedom must always be respected. A just society can conscript its citizens in time of war and a society committed to combating disease and illness can sometimes allow the pain and suffering of some illnesses in order to promote health or fight disease in other areas (Green, 1983, p. 377).

Green argues that limits can be placed by treating only those diseases or individuals that have a potential for substantial relief. Thus under Green's view a society may choose not to treat severe cardiac disease with artificial
hearts because of the poor results.

Unfortunately, Green does not solve the problem of the trade-offs required among the primary social goods. Green addresses trade-offs in determining what diseases to treat, not the compromises that may be necessary between primary social goods (i.e., limiting the liberty of the provider vs. providing equal access to health care for all citizens) and until this can be done, Green's theory is inadequate.

Daniels presents another Rawlsian argument. Because he sees disease as the deviation (below the norm) from the natural functional organization of a typical member of a species (3), he views the health status of the individual as central to the opportunities available to the individual. So, a diseased individual has fewer opportunities than someone without the disease. Thus,

if justice requires protecting fair equality of opportunity, then health care institutions should be governed by an appropriately extended principle of fair equality of opportunity (1981, pp. 160-161).

Health care services become analogous to the role of education for Rawls—as a means of tearing down barriers to opportunities.

It is crucial to this analysis to describe what impairs an individual's opportunities and what is the normal opportunity range. He describes the normal opportunity range in a given society as: "the array of life-plans
reasonable persons in it are likely to construct for themselves" (1981, p.158). This notion then is a society-relative notion and thus what disease may be treated depends upon a society's level of economic development and governmental structure. For example, assume that an individual is dyslexic and that this affects only his reading ability. If this individual lived in a non-reading society this disease would offer no impairment of opportunity. Thus no treatment would be required. However, in a society where reading is a critical skill, treatment would be required because of the effect on one's opportunity. Daniels' rights claim in sum provides: persons are entitled to treatment of those diseases which pose a barrier to an opportunity that falls within the normal opportunity range.

Only those services which treat diseases that are barriers to opportunity are covered by his theory. He determines which disease ought to be treated by using the following guide: "...it will become more important to prevent, cure, or compensate for those disease conditions which involve a greater curtailment of normal opportunity range" (1981, p.159). However a question remains, how do we choose between services which "remove serious impairments of opportunity for a few people and those which remove significant but less impairment from many" (1981, p.171). He recognizes
this problem, but believes his approach provides no answer.

What does asking for the restoration of normal opportunity range mean for the terminally ill, on whom we lavish exotic life-prolonging technology, or the severely mentally retarded? We are not required to pour all our resources into the worst cases, for that would undermine our ability to protect the opportunity of many others. But I am not sure what the approach requires here, if it delivers an answer at all. Similarly, the approach provides little help with another sort of hard case, the resource allocation decision in which we must choose between services which remove serious impairments of opportunity for a few people and those which remove significant but less serious impairments from many. But these shortcomings are not special to the approach I sketch: distributive theories generally founder on such cases (Daniels, 1981, p. 171).

A few words of qualification are necessary. Daniels (1982) gives a much broader meaning to opportunity than Rawls. His argument is not limited to opportunity for jobs and careers but opportunity "relative to that portion of the normal range which the individual's skills and talents would ordinarily have made available to him" (p. 530). For Daniels normal opportunity range is not only culturally relative, but also age-relative. If this were not the case, his theory would be age-biased, since careers and jobs are limited for the elderly. Health problems would not pose barriers since on the narrow reading of opportunity the elderly have few or no opportunities, thus making them ineligible for most health benefits.
But, since Daniels endorses the idea that being normal is defined as a statistical notion, there will still be an age-bias in the allocation of resources. For example, suppose you have an extraordinary elderly individual who at the age of 75 is running marathons. This individual is injured in a race and finds that every time she runs she gets severe pain in her right knee. The pain comes only with running, not with walking. Most individuals her age do not run marathons, so that her inability to run does not prove to be a barrier to her normal opportunity range. Thus, even though help is available for her, on Daniels' account it would not be guaranteed. The point of this example is that health care is important for many reasons, not just because it contributes to one having a normal range of opportunity. Health care services can enhance one's capabilities to do whatever he so chooses, even when this is not part of one's "normal range of opportunity".

Furthermore, the statement of the principle is ambiguous. Buchanan (1984) points out two interpretations of this principle. Recall that Daniels defines the normal opportunity range as:

the array of life-plans reasonable persons in... (society) are likely to construct for themselves (1981, p. 158).

In a later article (1982) Daniels discusses opportunity as:

relative to that portion of the normal range which
the individual's skills and talents would ordinarily have made available to him (p. 530).

Does this mean reasonable for everyone to pursue? If so then the list of health care services would be quite modest. If he means that the plan be reasonable for someone to pursue, then it becomes very strong, since it will include life-plans of the very talented. On this strong interpretation, the potential drain of resources required by the principle will make it impossible to comply with its directive. Moreover, one's skill level is clearly dependent upon the opportunities one has for their development. Yet Daniels defines the normal range as partially dependent upon this skill level. This introduction of one's skill level as defining of the normal range of opportunity is circular, i.e., one's skill level is dependent upon one's opportunity which is dependent upon one's skill level. The primary problem with Daniels discussion is discerning his meaning of the 'normal opportunity range for reasonable people'.

Daniels has presented us with the most systematic treatment of health care rights. He has provided both a foundation for the rights claim and given content to the claim within a Rawlsian theory of distributive justice. Though he has provided a principle which will assist us with making decisions about what services are to be offered in the society, his approach is inadequate.
Furthermore, Daniels, by adopting a Rawlsian framework is forced to accept an equal distribution when an unequal distribution does not maximize the position of the worst-off representative person. Thus if we have some health care service that can help some, but not all, then we must not use it. If resources are limited (even moderately so) it will never be the case that the worst-off representative person will be made better off by some unequal distribution.

In summary, this section has reviewed the various approaches used to establish a right to health care. The natural rights framework and establishing a health care right within a Rawlsian framework are inadequate to justify such a right. In addition to the problems noted, the strength of Green's and Daniels' arguments ultimately depends upon how well this theory of justice can be defended. Specifically, Green's theory depends not only upon whether one agrees that health care is a primary social good, but whether the difference principle is correct in advocating a theory of distribution which requires an equal distribution unless an unequal distribution improves the condition of the worst-off representative person. Daniels theory depends upon an interpretation of equality of opportunity and health care being related to or directly affecting opportunity. In Chapter Three I argue that the Rawlsian theory of justice is flawed because the difference principle fails to recognize
that individuals are indeed risk-takers and that by not holding individuals responsible for their risk-taking, we infringe on the liberty of the risk-averse and upon the risk-takers who are willing to pay the cost of their gambles. Thus, neither of the proposed approaches to justify a right to health care is adequate. They may convince an individual that he has a moral obligation to help, but until they can justify sanctions to enforce these obligations, no government intervention to redistribute the wealth is justified. What is needed is a theory of distributive justice, of which a pattern of health care is merely a consequence.

A challenge to the libertarian

The rights and decency arguments have been challenged by the libertarians, who within a framework of justice, argue that it is unjust to tax individuals to support health care services for the poor. Obviously, their argument too depends upon the adequacy of their theory of justice. But before examining this in detail I will show that the libertarian is too quick in dismissing a governmental role in the distribution of some limited health care services. There are good reasons to justify a redistribution of wealth for the development and delivery of health care services even given the ideological framework of the libertarian. Importantly, these reasons do not appeal to utilitarian or
Rawlsian arguments which are, for the most part, rejected by the libertarian and opponents of government involvement in either the payment or delivery of health care services. The reasons I put forth are, rather, reasons of enlightened self-interest—reasons not easily set aside even by opponents of these programs. Before doing this, however, I must discuss the characteristics of the health care delivery system.

The health care system is a complex mixture of research, education, and patient care services, requiring all three for it to be an effective system. Without research at all levels, new discoveries regarding normal physiology, pathophysiology, and treatment modalities would not occur. Without a broad educational system, including basic entry level education and specialized education, the system would lack qualified practitioners in all fields. Adequate patient care services depend upon the quality of the educational system and research developments. The advances being made today in research areas will determine what services will be available five years from now. Less obvious, but equally important, is the effect that research and education have on the patient care delivery system. To produce practitioners in the health care field, a delivery system must be available to the student for observation, practice, and learning. Without access to this system
during the educational process, fewer and less capable practitioners will be produced. Researchers must have access to this patient care delivery system also. At some point in the development of therapies and treatment modalities, a researcher must have access to patients to "test" their discoveries. For example, without people like Barney Clark, the artificial heart transplant program could not make advances. Thus, not only is the health care system a complex mixture of research, education, and patient care services, it is an interdependent system that thrives because of the mix.

The health care delivery system is not one in which demand for a particular product will necessarily guarantee its development or availability. For example, someone with AIDS today cannot buy the service needed (treatment for the condition), no matter how wealthy the individual is. No treatment currently exists. Unless there is an extensive supporting structure of research and education and a delivery system for students and researchers to access, the health care delivery system will be quite limited in its offerings and achievements. This fact will be an important one when we consider the question of whether an individual will be able to purchase the services he requires.

Recall the libertarian position. Persons desiring or needing services should purchase them from the appropriate
source. Those unable to pay for the service would either do without or be placed in the position of receiving benefits due to others' beneficence.

There is a major problem with this position. It assumes that the appropriate service will always be developed, and available for purchase. This seems unlikely if one only contributes money to the system at the point in time in which a service is required. If this is the case the cost of the service would be so high (research and educational component included also) that few could afford it. For example, suppose drug companies and other researchers used their own or private donations to research and develop a treatment for AIDS. Also suppose they were successful. To recoup the investment the cost of the drug would have to be extremely high. Critically, if the funding is not available for the educational and research programs, there would be no practitioners and no treatment modalities developed to be purchased. The point is that even if you were a multi-billionaire you would be unable to purchase the necessary health care service, because it would be unavailable. Given the libertarian model and some plausible assumptions about how people would choose to spend their money there would not be much there to purchase.

Nozick and other libertarians might argue that individuals within the society would freely support these
institutions, that no tax to finance these services would be needed and no government involvement is required. He reasons that if the members of the society want the service, they will see to it, through voluntary contributions, that the service is available. Furthermore, Nozick believes that individuals within the society will contribute to all sorts of causes, so that it is reasonable to assume that money would be available for some "free health care services" for the poor.

This does not totally solve the problem—the problem is not how does John Smith who is unemployed with no health insurance afford health care services, but rather without adequate financial support there will be no health care services to purchase. The real issue is how do I assure myself that the health care services I will need are available at a point in the future when I am in need. The libertarian is wrong in assuming that the health care system will survive as a sophisticated and responsive system, with only revenues generated through fee for service and charitable contributions. A health care system under the libertarian requirements would be inadequate to meet most people's needs because the services would be scarce, specialists difficult to find, and all available services would go to the highest bidder.
One may ask, what is so different about health care services that makes government necessary to meet the need? When there is an interest or need for some other commodity, let us say a faster desk-top computer, no government involvement is necessary. Companies research and develop new products in response to demand in all sorts of ways. Why not in the health care field? Because there are very different conditions applying to the purchase of health care. Since need is the sole reason why someone wants to purchase a health care service and this is independent of who can afford it, many services can only be provided at a loss. Such a business arrangement, that is investing large amounts of money into development with no possibility of recouping the expenses, surely could not work in most industries. Faced with such a prospect, the prudent business decision is not to begin the research. For example, passed by Congress in 1982 and amended in 1985, the Orphan Drug Act specifically provides for the development of drugs for rare diseases by offering financial incentives to companies. Without such assistance, no company was willing to meet the demand for these service because it was not profitable.

There are other diseases and conditions, though, such as Huntington's Disease, ALS (Lou Gehrig's Disease) and muscular dystrophy, which affect such a small number of persons that there is virtually no commercial value to any drug which is useful against them. Under these circumstances, it is not financially feasible, except as a public
service, for a pharmaceutical manufacturer to expend research and development funds on drugs for these rare diseases or conditions. As a result, drugs for rare diseases and conditions are commonly referred to as "orphan drugs." They generally lack a sponsor to undertake the necessary research and development activities to attain their approval by the Food and Drug Administration (FDA) (House Report No. 97-840, p. 3578).

Many other services may be profitable at some point in the future, or never profitable because of the cost of the service. Most often the payment decisions are not made by the buyer, but by a third party. The widespread use and improved technology for treatment of renal failure is another example of a service that only became widely available after it was government supported. In fact the cost of treating renal failure is almost solely borne by the federal government because it cannot be provided at a profit. Health care decisions are quite different from the business decision to build a faster computer. Unless we wish the decisions about what health care services ought to be available (not just who can have access to them) to be based solely upon the profit margin, some form of taxation is required to ensure that a wide range of services are available for purchase.

One possible response from the libertarian to the above arguments is that these are not common diseases and because of this he is willing to assume the risk. It is more important to him not to have his liberty interfered with than to
prepare for such a chance. The problem with this response is that the above argument is not limited to rare disease. The present vaccine crisis that is looming in the United States is just one such example. Modern medicine has taken pride in the development of vaccines that have been successful in decreasing or eliminating certain disease; e.g., diphtheria, polio, measles, small-pox, mumps. This success is being threatened because drug companies are refusing to manufacture vaccines. They are refusing because such production is no longer profitable. Recent legal settlements have made the production of these vaccines unprofitable. In fact, the House of Representatives, in H.R. 1780—the Vaccine Injury Compensation Act, has recognized this very problem.

(2) While childhood vaccination programs have prevented death and reduced suffering from some common communicable diseases, such as polio, these same programs have, in an unknown number of cases, been associated with the injury, illness, disability, or even death of some inoculated children and others.

(3) In some of these instances, vaccine-related injuries cannot clearly be attributed to the fault of any particular party. Thus, in such instances the traditional fault-based tort system offers no effective mechanism for compensating the injured individuals.

(4) Pendency of large numbers of tort claims against vaccine manufacturers and health care providers has threatened the continued supply of certain vaccines shipped in interstate commerce because manufacturers and their insurers are unable to estimate with any reasonable certainty the extent of their potential liability.
The loss to us all if no vaccines are produced will be great. Even if an occasional child is not vaccinated at the present time, they acquire some protection from the fact these diseases are rare. If none were vaccinated then all would be at greater risk and the diseases would be common. Furthermore, if enough individuals decided to subsidize these vaccines so their children are protected, children not vaccinated would benefit too, since the incidence of the disease would go down. Thus, this response by the libertarian approach would create a free-rider problem. To avoid this, a required subsidy, i.e., a tax, would be required.

Moreover, the libertarian should recognize that in some circumstances not providing services to others could be more detrimental to oneself in the long run. For example, the poor in my society have begun to develop hepatitis at an alarming rate; by not treating them, I place myself at an increased chance of being infected and even though I have the resources to buy treatment if I become sick, it is certainly better for me if I treat these other individuals and prevent the spread of the epidemic and never become ill. It is in my self-interest to treat these individuals. This is the same argument that Buchanan (1984) gives to justify a distribution of health care services to some individuals—that is, for the protection of the public health. For
example, I may have no desire to pay for health care services for my neighbor in all cases (i.e., pay through taxes), but there are certain diseases that my neighbor may contract (e.g., hepatitis) that I would gladly pay to treat, rather than risk my own health. This is done not because of any motives of beneficence or kindness, but rather from motives to protect the public health, and in particular to protect my own health.

Thus, it is in everyone's self-interest to contribute freely in order to ensure that one's needs will be met in the future and that one is protected from contact with some diseases. However, even though everyone should recognize that it is in his or her self-interest to do this, there will be a free-rider problem. For example, suppose you are in this society and it is time to pay your share. Individuals reason that their personal contribution does not matter, in that if enough people give to achieve the decent minimum, then their contribution is not needed; and if most people do not give, then the contribution is wasted. Furthermore if people are not sure that others will give, then they will tend not to give. Thus, this giving must be forced to ensure that all will give.

But the argument presented in the last few pages has its limits. It is only successful in guaranteeing treatment for some diseases. The libertarian can still claim
that there is no reason to treat the poor when they have noncontagious diseases for which well established treatments have been developed. He runs no risk of contracting the disease and there is no research value in treating these individuals since effective treatment already exists. However, the argument is successful in demonstrating to the libertarian that there are some services which should be subsidized and available to all.

This section presents an argument to justify government intervention in the distribution and management of health care services. The reasons for government's involvement have nothing to do with an obligation to help others, but rather as protection for oneself and family against some diseases. This argument should be attractive to the libertarian for the same reasons he belongs to a protection agency (fear of harm, inability to protect self and family alone). This argument has assumed that the basic tenets of the libertarian theory of property and entitlement are correct. Assuming these basic tenets we find that the services available to the poor will be restricted. It is time to turn our attention to these basic tenets and determine the correct theory of justice.
Summary

This chapter has reviewed the present arguments both for and against a government's involvement in the distribution of health care. The arguments given by those who believe the government should provide health care services to the poor and others were found wanting because they fail to justify the redistribution required to provide these services. Moreover, to justify this redistribution of health care services, one must consider the theory of justice upon which it must rest. The argument given by the libertarians was criticized because it fails to recognize that the same reasons for belonging to a protection agency can be offered to support the state's action in providing some health care services. But in reviewing both sides of the right to health care controversy it is apparent that the fundamental issue is broader than health care services. The fundamental issue is the correct theory of justice. Health care distribution is simply a consequence of this theory. The next chapter develops and defends a theory of justice that melds the insights of Rawls, Nozick, Ronald Dworkin, and David Gauthier.
CHAPTER III
A PRINCIPLE FOR DISTRIBUTIVE JUSTICE

Introduction

Much of the preliminary work done in the area of distributive justice has been concerned with determining a criterion of a fair or just distribution. Several criteria have been suggested, based upon such things as need, equality of welfare, contribution, and merit. Most writers recognize that to attempt to base a criterion of distributive justice upon just one factor is naive and inadequate. It is generally recognized that the principle of distributive justice must include not only terms of fair cooperation, but considerations of liberty and recognition of our desire to be free from interference. Furthermore, the idea of equality (at least in some weak sense) has been central to most conceptions of distributive justice, i.e., that whatever the criterion is, it must be applied in a like manner. Indeed one can broadly construe even Nozick's theory as including this notion of equality—that all persons have the equal right to private property.

To illustrate the sort of cases that considerations of justice are usually thought to apply to, consider the following situations.
Example 1: Jack and Jill have equal talents (assume this can be determined), but Jill is a harder worker and thus more successful. Furthermore, Jack and Jill have the same needs and preferences so to be happy they require an equal amount of wealth. Jill is able to produce enough to achieve the success and wealth that meets her needs, and makes her happy. Jack, even though equally talented, isn't equally industrious. To require Jill to subsidize Jack seems to many to be unfair.

Example 2: John happens to be lucky enough to be born the son of a billionaire, who provides for John's every need, want and desire. Sue has the unfortunate luck to be born the daughter of an unemployed coal miner who is unable to provide for her needs. Many see the advantages John has and the disadvantages that Sue experiences as unfair. (Of course, the libertarian will deny the unfairness of this situation, if the billionaire has acquired his wealth justly. This objection is addressed later in this chapter.)

Example 3: Farmer Jones and farmer Smith are hard workers and equally talented at their work, but Jones lives in Georgia and Smith in Ohio. Bad droughts the last few years have been hard on Jones and he is about to lose his farm. Some will say that Jones' loss of his farm through no fault of his own is unfair.
Each of these examples are constructed to illustrate different concerns raised when discussing justice. The Jack/Jill example raises the issue of one's work effort—should a just distribution of resources be sensitive, all other things being equal, to one's effort? The John/Sue example raises the problems of unequal starting points and the fairness of inheritance—given that John/Sue are equally undeserving of their starting points how should we distribute the advantages and disadvantages of these starting points? Finally, the farmer example highlights the role of luck (or lack thereof) in achieving one's goals. Should a theory of justice take one's luck into consideration and should it try to correct for bad luck, like farmer Jones' at the expense of others' good luck? Thus each of these examples point out different instances in which there is a question of fairness in the distribution of social resources and raises the question of how best to account for one's contribution, merit or desert, and luck. Any account of distributive justice must be able to account for these aspects of justice.

The task at hand then is to defend a theory of justice that will assist us in deciding what is a fair distribution when applied to groups of individuals living within a political framework.
The Principle

I will argue that justice requires:

A division of social goods that results in each individual receiving enough goods and services to allow achievement of a satisfactory welfare level; consistent with the most extensive liberty to choose and pursue one's life plan, compatible with a similar freedom for all.

My defense of this principle, the satisfactory welfare achievement principle, (SWAP), will proceed in two stages. First I will argue for end-result principles of distributive justice over the pure procedural conception of justice formed by libertarians. Redistribution can, I will argue, be justified by its effects and not solely as redress for past injustices. Secondly, I will argue that the proposed conception of justice is preferable to other plausible contenders for an end-result principle of justice.

What distributive decisions will be made in the three examples presented in the introduction? In the Jack/Jill example the principle will require no redistribution from Jill to Jack. The principle does not require that Jack and Jill be equally happy or satisfied, nor does it require equality of welfare. As long as Jack has been given the equal chance to achieve, no further distribution is required. In the second example, John, the billionaire's son may have to give up some of his resources in order that Sue will have the services and goods she needs to achieve a
satisfactory welfare level. However, there is no require­ment for equalizing John's resources, unless this is what is required for all individuals to achieve a satisfactory wel­fare level. Finally in the farmer example the principle will provide for additional resources to Jones if the loss of his farm will bring him below the satisfactory welfare level.

SECTION I: A JUSTIFICATION FOR REDISTRIBUTION

Introduction

In this section two questions must be answered: 1) 'Why ought we redistribute transferable goods and services, and not just accept a distribution arrived at through a market system, free from theft and fraud?'; and 2) 'Why, given that individuals own their bodies and talents, are they not entitled to all of the benefits generated by these talents?' My answer has to do with the influence the social structure has over the development and production of, and reward for these social goods—my claim is that the rules of the game change once we move into a social setting. One cannot simply assume (as Nozick does) that one's entitlements in a state of isolation defines a fair distribution in a social situation. Given that one excels within a community, one needs to recognize that many factors, in addition to one's own strengths, made such accomplishments possible. Often,
one's accomplishments are a function of the conditions of supply and demand, rather than one's particular talents. For example, an artist may be very talented, able to produce works without much or any help from others. However his success in society is a function more of the interest of others and the scarcity of this talent, rather than simply innate abilities. Since many factors account for the rewards of such a talent, one cannot assume that this talent entitles the artist to all of the benefits gained from the talents. Traditionally, these arguments have claimed that because one owns one's talents, one is entitled to the gains gotten from these talents. Most of these arguments have used some version of Locke's labor theory of acquisition to establish ownership, and to handle difficulties that arise in these arguments, some version of the Lockean proviso to limit ownership rights. I argue in this section that the strategy of using the Lockean proviso to limit ownership rights is fraught with many difficulties and that one can generate very different interpretations of what is required in order to prevent a proviso violation. I suggest that Nozick's arguments are inadequate to justify his theory of property because he fails to take seriously the compensation required for the appropriation of commonly used resources and for the costs necessary for the operation of the market.
I also argue that it does not necessarily follow from the premise that I own my body/talents to the conclusion that I am entitled to all that flows from these talents.

The Lockean proviso revisited

Consider the following situation. A number of shipwreck survivors are washed up on a deserted island moderately endowed with resources (but not enough for each individual to live on his own, interaction will be necessary), and rescue is unlikely for many years. Assume further that no instruments or goods from the ship make it to shore. What is the fair distribution of the resources on the island, i.e., land, food, shelter? In this example it is clear that no one has any a priori entitlements to any of the land. That is, no one before coming to shore can be said to own part of the island. What principles should be used for appropriation?

Gauthier gives an analysis of a similar situation based upon his interpretation of the Lockean proviso. His interpretation of the proviso is: "the proviso prohibits the bettering of one's situation through interaction which worsens the situation of another" (Gauthier, 1986, p.205). In section II, I examine this formulation in detail. At this point we can simply assume Gauthier's interpretation and see what follows. Gauthier's response to the hypothetical
island problem is the following. He assumes first that each family (thought of as an individual unit) provides for its own needs, interacting non-cooperatively with other family units. One individual, Eve, seeks an exclusive right to a certain portion of the island. In assessing the proposed right Gauthier tells us we must consider whether the proviso is violated—that is, is Eve bettering her situation by worsening the situation of others? If not, is some other person, in interfering with a claim to exclusive use, violating the proviso. If so, then the right is established. Once this right is established, the right-holder can demand market compensation from any violator. Now it seems clear that Eve is intending to better her situation, but is she necessarily worsening the condition of others by restricting their use of "her" land? The answer to this question depends somewhat upon the land Eve is claiming.

Now we might suppose that Eve seeks a part of the island so large that she would leave her fellows worse off than before; the land remaining in common might support them less well than the entire island supported everyone. Eve's claim would then violate the proviso. But she need not seek such a large appropriation. . . . She may produce sufficient food to meet the needs of several families, so the others, who formerly grew their own food, may become specialist craftsmen and craftswomen, with benefits to all. Hence her appropriation may enable everyone to improve her situation, in relation to the base point set by use in common, so that it does not violate the proviso (Gauthier, 1986, p. 215-216).

Thus, Gauthier is clear that such movement from ownership in
common to individual ownership will be, or should be, mutually beneficial or at least not detrimental to any. By this he means that appropriating land is permissible only if others are not made worse-off. Since they no longer can use what they previously could they are (strictly speaking) made worse-off. But others may be made better-off, for at a minimum, this person no longer may use the land in common and by appropriation may make others better-off through increased opportunities.

Thus the mutually beneficial nature of exclusive rights of possession provides a sufficient basis for their emergence from the condition of common use which is the final form of the state of nature (Gauthier, 1986, p. 217).

Nozick would give a similar analysis. Since no one owned the island prior to the arrival of the survivors, each individual can appropriate the resources as long as this appropriation is consistent with Nozick's interpretation of the Lockeian proviso: "A process normally giving rise to a permanent bequeathable property right in a previously un-owned thing will not do so if the position of others no longer at liberty to use the thing is thereby worsened" (Nozick, 1974, p. 178). So long as I do not worsen anyone's situation, I can collect all the resources I desire. What it means to "worsen" one's position however remains the critical issue. Nozick states (p. 178) "that any adequate theory
of justice in acquisition will contain a proviso similar to the weaker of the ones we have attributed to Locke". This weaker proviso claims that one is made worse by another's appropriation if he no longer is able to use freely what he previously could. I think Nozick has the following in mind. P's condition is worsened if someone (other than P) appropriates all or the last free portion of a natural resource. As long as there is enough for P's use, even if P cannot appropriate because his appropriation would worsen the condition of others, i.e., appropriating the last plot of land, other individuals' past appropriations have not worsened P's situation. Thus the proviso has not been violated. Nozick does not believe that a loss of opportunity to appropriate worsens one's condition. "(The proviso) does not include the worsening due to more limited opportunity to appropriate" (Nozick, 1974, p.178). He makes this claim because he does not think that individuals unable to appropriate property are necessarily worsened by a system allowing appropriation and permanent property. There are trade-offs, e.g., it increases the social product by putting the means of production into the hands of those who can most efficiently use them, that satisfies the intent behind the proviso. That is, "that there be enough and as good left over", is met because of the improved social conditions.
However even given this, worsening one's condition must be related to some base—worsening in comparison to what? Nozick recognizes that this is a problem and admits that this issue needs more discussion, "this question of fixing the baseline needs more detailed investigation..." (Nozick, 1974, p. 177). Nozick does suggest that the baseline situation depends upon no violations of the proviso in the past and he suggests (on p. 177 and in a footnote on p. 177-178) that the baseline is set at common use of untransformed raw materials and unimproved land.

Nozick will permit most of the island to be appropriated as long as there is some portion of the island left for "non-owners" to use. Furthermore, he will permit complete appropriation of the island as long as the appropriator compensates those who were using the remaining plot of land. Neither appropriation makes others worse-off, given Nozick's interpretation of the proviso and where he draws the baseline. Since Nozick accepts the weaker version of the proviso, all that is needed is that no one is made worse-off by such appropriation. Nozick argues, as does Gauthier, that appropriations which provide increased opportunities compensate for the private acquisition of property and guarantees that the "as good" requirement is met. If someone wishes to appropriate the remaining plot, which would violate the weaker version of the proviso, he may do so according to
Nozick, provided he compensates the others so that their situation is not thereby worsened.

The point of the above discussion is to illustrate the significance of defining the baseline and to demonstrate what is required to avoid a proviso violation. For Gauthier the baseline is set at what one has or lacks in the absence of others and for Nozick the baseline is set at what can be used in common prior to any appropriation. To appropriate resources available for common use one must not worsen the condition of others. Nozick however underestimates the cost of compensation in appropriation—he thinks that all that is necessary is that opportunities are increased or the social condition improved. He does not consider explicitly whether an individual can avail himself of these opportunities. Gauthier, on the other hand, specifically makes clear this requirement.

Before continuing we should note that the opportunities for others to improve their situation, must be effectively available. Eve must afford every assistance necessary to ensure that the new ways are known and accessible to those who must choose between adopting them and suffering loss (p. 292).

But obviously, if they can not benefit by these opportunities, then they are made worse-off. Therefore Nozick too must be concerned with the availability of these opportunities. Nozick agrees that a socially guaranteed
minimum provision is required for persons for whom "the process of civilization is a net loss, for whom the benefits of civilization did not counterbalance being deprived of these particular liberties" (p. 179). But a pure procedural conception of justice does not guarantee that an individual is able to take advantage of these new opportunities and a market operating free from theft and fraud will be unlikely to provide the individual the resources required to operate within this market. For example, consider a situation in which Jones appropriates a plot of land with suspected rich oil deposits. Jones has the expertise and knowledge to develop this property into a very profitable acquisition, but before Jones can appropriate justly, i.e., not violate the proviso, he must show that he does not worsen others' conditions. Suppose Smith has previously used this land, as all of the people of the town, as grazing land for their cattle. No one has previously owned the plot, rather all have used the plot of land in common. Furthermore, there is no other plot of land in the territory that can support the herd. Obviously Jones worsens the condition of others by his appropriation of this commonly used land. However Jones argues that he does not violate the proviso since the increased opportunities created by him owning and developing the property compensates for this appropriation. But simply creating these opportunities is not enough. Smith is
compensated only if he has the skills and resources necessary to benefit by this change. A market permitting Jones to appropriate by claiming that Smith is compensated by increased opportunities without redistribution to guarantee Smith the skills necessary to avail himself of these opportunities violates the proviso. What Nozick fails to see is that redistribution is required to ensure that appropriations occur without a proviso violation.

Thus, the Lockean proviso requires that an appropriation should not better one's situation by worsening the condition of others. If one assumes that the baseline is set by common use of natural and undeveloped resources then it would seem that any appropriation will worsen the condition of others by limiting one's use of this property. However if there is "enough and as good" left or one's life prospects are not diminished after the appropriation then one is not worsened merely by the lack of opportunity to appropriate that plot of land. If there is not enough and as good remaining or if one's life prospects are diminished, then other compensation is required. The fact that opportunities may be increased with private ownership of property can compensate for appropriating behavior but this is not guaranteed. Nozick underestimates what is required—in order to appropriate property in common use one must not make others worse-off by the
appropriation. Simply creating opportunities is not enough. Those who are worsened by these appropriations must be able to avail themselves of these opportunities. Nozick may be correct that private ownership of property guarantees more efficient and effective use of the property and that this ownership may create opportunities not present prior to the appropriation. But if those who are denied the use of a previously common asset can not take advantage of these newly created opportunities then they are made worse-off and the proviso is violated. It is not enough that new opportunities are created—these opportunities must be ones that those harmed by the acquisition can use. Nozick fails to see this point.

The remaining issue is the ownership right to man-made things or answering the second of our questions, 'Why, given that individuals own their bodies and talents, are they not entitled to all of the benefits generated by these talents?'

Nozick argues that, "things come into the world already attached to people having entitlements over them" (p. 160). Thus he holds that things generated from one's talents are one's own and that one is entitled to all benefits generated by these talents. His argument for this claim is examined in the next subsection.
The gains gotten from talents

Consider the following two cases. Samuel lives on a deserted island somewhere in the Pacific. He has bred a new species of plant—a plant that is discovered to have great healing powers. Samuel is an uneducated man, who has no formal training in biology and happens to like to tinker with plants. In fact Samuel has had no contact with other humans for the last 25 of his 30 years of life. Contrast Samuel's case with that of Josh. Josh lives in Boston and received a Ph.D. in plant physiology at Harvard. Continuing the research of his adviser and building upon recent discoveries in the area, Josh is successful in breeding a new species of plant that also has great healing powers. Samuel is rescued from the island and now he and Josh claim to own their respective species of plants and further claim that they can sell it to the highest bidder. Do both Josh and Samuel have the same entitlement to their work?

Nozick would argue that both are equally entitled to the fruits of their labor since both can be said to own their discovery.

But since things come into being already held (or with agreements already made about how they are to be held), there is no need to search for some pattern for unheld holdings to fit; and since the process whereby holdings actually come into being or are shaped, itself needn't realize any particular pattern, there is no reason to expect any pattern to result. ...In the non-manna-from-heaven world in which things have to be made or
produced or transformed by people, there is no separate process of distribution for a theory of distribution to be a theory of (Nozick, 1974, p. 219).

These species have come into existence owned by Josh and Samuel respectively and thus they are entitled to any gains as a result of their labor. Nozick gives the following argument to establish entitlement.

1. People are entitled to their natural assets.
2. If people are entitled to something, they are entitled to whatever flows from it (via specified types of processes).
3. People's holdings flow from their natural assets.

Therefore:
4. People are entitled to their holdings.
5. If people are entitled to something, then they ought to have it (and this overrides any presumption of equality there may be about holdings) (Nozick, 1974, p. 225-226).

However there does seem to be a difference between the two cases. Josh has been influenced and assisted by the present social structure that has helped him arrive at his present position. Samuel however has not benefited from the social structure. Some may argue that based upon these differences Samuel has a stronger entitlement claim to his product and is more deserving of any reward offered for this product. Josh on the other hand is not entirely responsible, thus he cannot be completely entitled. Nozick may or may not agree with this claim. If Josh has paid for his education (or the money was given him as a scholarship without contractual obligations), then he owes nothing back.
A great deal becomes embedded within the "specified processes" of premise two. But (I claim) it is impossible for Josh to completely pay his way. Josh has benefited from the social situation, including the work of those who have gone before him. Furthermore he has benefited by the state's support of the educational system and of others' contribution to his development. Unless he stands ready to pay the full cost, it seems some entitlement to the product is established by others.

Furthermore, this argument does not justify complete entitlement to the natural resources used in the production of some product. For example, I may be able to grow a bumper crop from a plot of land and my efforts surely entitle me to at least part of these crops, but why to the land also? Nozick's argument seems to guarantee me entitlement only to the crop (premise 2 above), yet he claims that this establishes an entitlement to the land also. Before I can be entitled to the land I must show that such an appropriation makes no one worse-off.

Nozick gives an example similar to the Josh/Samuel example above. A medical researcher synthesizes a new substance (from common substances) that effectively treats a certain disease and the researcher refuses to sell except on his own terms (Nozick, 1974, p.181). Nozick claims that this researcher owns this substance and can decide how it is to
be distributed. He does not consider the contribution of others to this product. Nozick reasons that since this man did not violate the proviso, and he developed this product from his natural abilities, he unquestionably owns the substance. He thinks the proviso has not been violated since there is enough of the natural resources from which the substance was made left for others to use. This case is different from someone owning the last of a natural resource, e.g., water, since the researcher has not appropriated the last of a natural resource, but instead he has taken a natural resource and developed it into a useful product. Even though he is refusing to give a dying person the substance to save his life, Nozick contends that the proviso has not been violated.

The fact that someone owns the total supply of something necessary for others to stay alive does not entail that his (or anyone's) appropriation of anything left some people (immediately or later) in a situation worse than the baseline one (Nozick, 1974, p.181).

Thus Nozick argues that the medical researcher (as both Josh and Samuel would be) is entitled to everything he can receive as a result of his work.

But there is a deeper issue here, which when recognized weakens the medical researcher's, as well as Samuel's and Josh's claim. Even if one can grant sole ownership of the product to Samuel and/or Josh, the value of the product in
society has more to do with the social structure and the economic conditions of supply and demand, than the individual's talents. There are many independent factors which influence the value placed upon products within a society. Because many of these factors have no real relationship to one's talents and because the social structure, in a very real sense, has permitted such rewards, one cannot be entitled to everything gotten within the social framework. Thus Nozick is wrong to assume that one's individual talents entitles one to the gains gotten from these talents. But if this is so, a result of this argument is that in the state-of-nature with no social framework or institutions, Nozick's argument works. Consider the Robinson Crusoe case discussed by Gauthier.

There are sixteen Robinson Crusoes, each living on a different island. Each is either clever or stupid, either strong or weak, either energetic or lazy. Each lives on an island either well or ill supplied to meet human needs and desires. No two Robinson Crusoes are alike in their characteristics and circumstances (so given sixteen of them, all possible combinations are realized). There is a clever, strong, energetic Crusoe living very comfortably on a well-supplied island. There is a stupid, weak, lazy Crusoe barely surviving on an ill-supplied island. In between are fourteen other Crusoes.

Each is equipped with a two-way radio, putting him in communication with the other Robinson Crusoes. Each knows how his situation compares with that of each of the others. Each is also able to build small rafts, not large enough to carry a man or woman, but sufficient to carry provisions of various kinds. The ocean currents will take these rafts from one island to another, but only in a
single direction, so that trade is impossible (Gauthier, 1986, p. 218).

Would an impartial principle of justice require that there be a redistribution of goods under these conditions? This is a crucial question for Nozick, Gauthier and us. Both Nozick and Gauthier will say 'no'. Nozick believes that this shows that redistribution in society is not required by an impartial principle of justice. Gauthier will say 'no' since in the state-of-nature no contract has yet been made. However, in a social situation Gauthier may say yes. I submit that Gauthier is right—that is, no redistribution is required in this case, but because one has not benefited from a social structure. Nozick fails to recognize that once social interactions occur and a social structure interferes (either positively or negatively) we no longer are operating under the same situation.

Once a social framework is in place Gauthier argues that one is only entitled to the cost of producing the product. This cost includes an amount that an individual requires to continue within the specified line of work. What he is not entitled to is an amount greater than his costs, available because of the scarcity of the product. Gauthier considers the case of Wayne Gretzky, a very talented hockey player (Gauthier, 1986, p.272). Because of this talent, and because of its scarcity Gretsky is in a position to extract
factor rent, that is an amount greater than is necessary to cover his costs, including an amount to induce him to play. The difference between the least amount that would induce him to play and the actual remuneration is the rent. Gauthier argues that one is not entitled to this rent since its redistribution will not affect one's freedom or decisions about how one will use his basic endowment. For Gauthier, the proviso gives us an entitlement to our basic endowments and the freedom to choose how we use them. According to Gauthier when a tax influences the decisions about how we use our endowments then it interferes with the working of the market and is unjustified. But when the tax only redistributes the factor rent no interference has occurred. Thus, once in a social situation the proviso gives us an entitlement to our basic endowments, but not to all of the gains these endowments may generate in a society.

I agree with Gauthier on the decision in the Robinson Crusoe case. However this leaves the remaining question of how are we to distribute resources once in society. I address Gauthier's argument in the next section and argue for a particular principle of distribution.

In summary, this section has argued against the libertarian's pure procedural conception of justice. Redistribution of transferable goods and services is required for two reason. A justified appropriation of naturally occurring
assets and resources available for common use requires that others not be made worse-off. This means either that "enough and as good" remain or one's life prospects are not diminished after the appropriation or that some other compensation is forthcoming. Both Gauthier and Nozick argue that "the enough and as good" requirement is met by the increased opportunities and advantages created by a system of private property. But this is not quite enough. To ensure one is not made worse-off by an appropriation one must be able to use the opportunities created. Redistribution is necessary to achieve this end. Second, many of the gains or losses generated in a social system have no relationship to one's talents but have more to do with the social structure and economic conditions of supply and demand. One can not be completely entitled to gains generated from one's talents. Redistribution is required to recognize and maintain the role of these other independent factors, e.g., educational system.

Section II. An Explanation and Justification of a Principle of Justice

Introduction

In the previous section I have shown that being entitled to one's basic endowments does not entitle one to all the gains generated from those talents and further that ownership of natural resources cannot be established simply
by holding, working, or transforming that resources into something more useful. Such effort can only establish a partial entitlement to the product produced and one who has benefited by such use of a natural resource may owe compensation to those denied use of this natural resource. In this section I argue that in a society of moderate scarcity, justice requires a division of resources that allows achievement of a satisfactory welfare level. Such a distribution is required to ensure appropriations without violations of the Lockean proviso and because of compensation owed by those who have benefited or payments due those who have been harmed by the social structure. This division is governed by the satisfactory welfare achievement principle (SWAP) which states that justice requires:

A division of social goods that results in each individual receiving enough goods and services to allow achievement of a satisfactory welfare level; consistent with the most extensive liberty to choose and pursue one's life plan, compatible with a similar freedom for all.

I will show also that this principle is the preferred choice of the social contractarian. I will first explain what SWAP requires and then offer a justification for why this is the correct principle for a just distribution.

The domain of social resources

There are at least three types of goods that have been considered appropriate for redistribution. There are those
resources that are clearly transferable, i.e., money, property, food; resources that are clearly not transferable, i.e., talent and abilities; and finally, resources that are best described as services that enhance or improve the chance that one reaches his life goal, i.e., health care, education. I argue that the only reasonable understanding of the social goods subject to redistribution are goods of types one (transferable goods) and three (services that enhance the prospect of achieving one's life goals). When discussing talents/abilities we can only talk of a redistribution of the gains produced from these talents. However, Rawls and Dworkin seem to suggest that if talents and abilities could be redistributed then that might be in order. They imply that talents and abilities are community assets and that any gains produced as a result of these talents should be considered community property and thus subject to redistribution.

We see then that the difference principle represents, in effect, an agreement to regard the distribution of natural talents as a common asset and to share in the benefits of this distribution whatever it turns out to be. Those who have been favored by nature, whoever they are, may gain from their good fortune only on terms that improve the situation of those who have lost out. The naturally advantaged are not to gain merely because they are more gifted, but only to cover the costs of training and education and for using their endowments in ways that help the less fortunate as well. No one deserves his greater natural capacity nor merits a more favorable starting place in society. But it does not follow that
one should eliminate these distinctions. There is another way to deal with them. The basic structure can be arranged so that these contingencies work for the good of the least fortunate (Rawls, 1971, pp. 101-102).

Rawls sees natural talents and abilities as arbitrary from the moral point of view. Dworkin similarly argues for equality of resources, defining resources quite broadly to include talents and handicaps, as well as transferable goods. One of the reasons for redistribution is because we lack individual ownership and entitlement to these talents.

However, it is unclear what is meant by "redistribution". Is the intent to equalize, to the extent possible, the talents and handicaps individuals have? If a mechanism were developed tomorrow that could divide talents, would Rawls and Dworkin give up part of their talents to the less talented, viewing this as a requirement of justice? Nozick has the same concern. Referring to the same passage Nozick asks:

And if there weren't "another way to deal with them"? Would it then follow that one should eliminate these distinctions? What exactly would be contemplated in the case of natural assets? If people's assets and talents couldn't be harnessed to serve others, would something be done to remove these exceptional assets and talents or to forbid them from being exercised for the person's own benefit or that of someone else he chose, even though this limitation wouldn't improve the absolute position of those somehow unable to harness the talents and abilities of others for their own benefit? (Nozick, 1974, p. 229)
If this is Rawls' and Dworkin's intent I think they have thrown too much away. In an attempt to sever the ownership relationship between one's talents and oneself, they have denied that individuals have a privileged status with respect to their bodies. If this is so, then it seems to follow by analogous reasoning that redistribution of one's body parts is justified. After all, to use Rawls' and Dworkin's language, I have done nothing to deserve my good health, thus I am not entitled to the benefits of my good fortune. For example, the technology presently exists for transplantation of kidneys, with little risk to a healthy donor. If one's talents are to be distributed to improve the condition of the worst-off representative person, or to equalize resources, then, it seems, those with two healthy kidneys are obligated to "share" this resource. If Rawls and Dworkin find this result troubling, then they must show us why we can redistribute talents, but not redistribute body parts.

Some may claim that this is an uncharitable reading of both Rawls and Dworkin. Rather what they actually intended to do is to separate the benefits gotten from talents, from the talents themselves. I agree with Rawls and Dworkin that such a separation is needed and that redistribution of these gains is necessary. However, I disagree with the reasons
such redistribution is needed. Redistribution is required, not because of a lack of individual entitlement to the talent, but because one can not be said to be entitled to all that flows from these talents when these gains are made within a social framework. Rawls too, in latter writings, seems to recognize the problem with his earlier position. He states:

Thus even if an equal distribution of natural assets seemed more in keeping with the equality of free persons, the question of redistributing these assets (were this conceivable) does not arise, since it is incompatible with the integrity of the person (Rawls, 1975, p. 36).

A serious problem remains however, that has its origin in Rawls' difference principle. The principle requires that resources be distributed so that the worst-off representative person is as well-off as he can be. This principle requires such assistance without consideration of why individuals may be in this situation and leads to slavery of the talented. The talented are forced to assist this group even when it seems to infringe upon the liberty of the talented by making them (the talented) pay the cost of others' choices (the worst-off group). Now it is clear that Rawls does not think the talented must use their talents, but only once they do choose to use their talents they must improve the worst-off group. For example, suppose I am a good computer programmer, and can make a good deal of money doing
this type of work. In fact the most money I can make is by using my talents in this manner. Suppose also that I hate this type of work and prefer instead to write music, although I am not very good at it and can make only enough money to survive. Rawls would not say I must work as a programmer to improve the condition of the worst-off person because of the priority of his liberty principle, but once I choose to use my talents, I can do so only to improve the worst-off person. For Rawls this requirement is not conditional upon the welfare level of the worst off. Even if this group has achieved a satisfactory welfare level, I am still required to work for the benefit of this group or if my choice to compose music places me in this group, others must improve my condition. It seems that this unconditional requirement will undermine Rawls' claims about individual autonomy and responsibility. On this account, the worst-off person may not be held responsible for his/her choice, which forces the talented to subsidize the failures and choices of this group. This interferes in a real sense, with individual liberty. For not only do the talented have to pay the cost of their choices they must subsidize the choices of others. It is the requirement that we must assist all those in this group unconditionally that worries me—if I remain in this class because I gamble with my talents or abilities or resources, why should I be entitled to the social resources
you produce, just because I belong to a particular group in the society? How is this holding me responsible for my life plan and how is this giving you the freedom to pursue your life goals as you see fit? It is not—there is an independent reason to justify such interference if individuals have not had the goods and services necessary to achieve a satisfactory welfare level, but once such an opportunity has been given, the reason for interference is removed, and the interference becomes excessive.

Rawls will probably claim that we need to consider what would maximize the condition of the worst-off representative person in the long run, and it is much better in the long run if we hold them responsible. However this seems to miss the point. It is not merely the case that holding these individuals responsible maximizes their status but requiring other individuals to subsidize their life choices interferes unjustifiably with the life choices of these other individuals.

Dworkin, on the other hand, argues for a similar result, but with a different strategy. That is, Dworkin and Rawls both seem to want their strategies to benefit the worst-off representative groups, but their means to this end are different. Rawls argues for the difference principle, while Dworkin argues for equality of resources. Dworkin is
particularly concerned with equalizing resources, broadly construed, to include talents, abilities, and handicaps. For Dworkin, personal preferences and choices made with the resources available to you must be taken into account. Dworkin believes that there is an important distinction between those resource poor individuals who have gambled and lost their fair share of social resources, and those individuals who never received their fair share. Although the former is not a problem for justice, the latter is.

The difficult question Dworkin must address concerns the distribution of non-transferable goods—talent, ability, and handicaps. Dworkin argues that inequalities relative to handicaps can be "equalized" to some extent with a strategy that mimics the operation of current health insurance companies. He tries to use this insurance strategy to demonstrate a means to equalize talents. As a simplifying assumption Dworkin assumes that talents can be measured and that individuals will readily volunteer the talents they have. I will grant this difficult empirical claim to Dworkin for the sake of argument and examine and criticize his strategy independent of this claim. How is it that we can "distribute" these non-transferable resources? There are at least two ways. One way is to divide up the property rights in all goods, including the non-transferable resources, so that each has an equal share in these resources.
To understand this strategy consider the following. In a society of \( n \) people each would own \( 1/n \) share of the labor power of each person—thus I own only \( 1/n \) shares of my own labor. Also assume that there is equality with respect to the transferable goods within society. Hence, a highly talented individual and a poorly talented individual have the same resources to "buy" back their own talent. Each share of the talented individual's resource is going to be more costly, measured as the amount of goods produced by one unit of talent. The result of this means that the talented individual will be unable to "buy back" all the shares of his talent, leaving his talents owned by others within the society. Thus the highly talented individual will be forced to perform the service that brings about a high wage (use his talents) even if he would prefer to engage in a less skilled (and less profitable) activity. Dworkin finds this objectionable because he believes we should have the liberty to choose not to use our talents and under the equal division distribution this will not be possible for the talented.

The second way, and the one advocated by Dworkin is an insurance market. He uses this strategy to determine a level of compensation that would be agreeable within a society. Dworkin states:
But let us nevertheless try to frame a hypothetical question something like the question we asked in the case of handicaps. Suppose an imaginary world in which, though the distribution of skills over the community were in the aggregate what it actually is, people for some reason all had the same antecedent chance of suffering the consequences of lacking any particular set of these skills, and were all in a position to buy insurance against these consequences at the same premium structure. How much insurance would each buy at what cost? If we can make sense of that question, and answer it even by fixing rough lower limits on average, then we shall have a device for fixing at least the lower bounds of a tax-and-redistribution program satisfying the demands of equality of resources (Dworkin, 1981b, p. 315).

Now Dworkin thinks this "hypothetical" insurance strategy will avoid the slavery of the talented problem. To understand this, we must examine Dworkin's reasons.

Dworkin believes that people will insure themselves at a low talent level to avoid paying high premiums if they lose the gamble (and end up being highly talented). Dworkin argues that individuals will not insure themselves at the highest talent level even though the chances of winning are extremely high. This is so because the person will want to protect his winnings if he loses the gamble. If he does choose to insure at this high level, and loses the insurance game, then Dworkin believes he will be a slave to his maximum earning power. This, Dworkin believes, should be avoided. Rather individuals will all insure at some low level, presumably at a level that will meet their needs if they totally "win" the game and have little or no talent,
and those who "lose" the game and have more talent than their insurance level will have premiums that are reasonably easy to pay. Thus Dworkin thinks his hypothetical insurance strategy will ensure that all have their minimal (talent) needs met.

In the first (world) those who are relatively disadvantaged by the tastes and ambitions of others, vis-a-vis their talents to produce, are known in advance and bear the full consequences of that disadvantage. In the second (world) the same pattern of relative disadvantage holds, but everyone has subjectively an equal antecedent chance of suffering it, and so everyone has an equal opportunity of mitigating the disadvantage by insuring against it. The argument assumes that equality prefers the second world, because it is a world in which the resources of talent are in one important sense more evenly divided. The hypothetical insurance argument aims to reproduce the consequences of the second world, as nearly as it can, in an actual world. It answers those who would do better in the first world (who include, as I said, many of those who would have more money at their disposal in the second) by the simple proposition that the second is a world that, on grounds independent of how things happen to work out for them given their tastes and ambitions, is more nearly equal in resources (Dworkin, 1981b, p. 331).

Dworkin uses this hypothetical insurance market as a means of structuring a tax schema that will bring the same results. He argues that a graduated tax, modelled after the hypothetical insurance model will result in more equity in the distribution of talents and abilities.

There are serious problems inherent in Dworkin's strategy. My disagreement with Dworkin is not so much with where
he ends up but the means he uses to arrive at his redistributional outcomes. Like Dworkin, I am concerned with the distribution of the "gains gotten from talents" and with the basic level at which people must live. I, too, offer an argument that separates entitlement to one's talents from entitlement to the gains gotten from these talents.

However, Dworkin's argument is unconvincing since it seem highly unlikely, given the odds of winning, that individuals will choose to insure at a low level. I think Dworkin must have some notion of collective choice in mind—i.e., if each of us chooses to insure at high levels, the insurance company will have to have very high premiums, probably matching our income, just to avoid bankruptcy. Thus each of us, independently of our insurance gamble, will be forced to work at our maximum earning potential. Apparently this is what he thinks we must avoid. However this seems to be a classic prisoner's dilemma—that is, we are all much better-off if we cooperate and insure at a low level, but individually, I can do better if you cooperate and I do not. For example, suppose in the following matrix both "Column" and "Row" decide to insure at high levels. In a world in which everyone insured at high levels the insurance companies would have to make the premiums quite high to avoid bankruptcy. So the premium one would have to pay given
this scenario would be prohibitive. However, assume both "Column" and "Row" decide to insure at a minimal level. Since most people will be born with more than this minimal level of talent the insurance company will have to pay infrequently which will make the premiums low. But suppose "Column" decides to insure at high levels, while everyone else insures at low levels. Since only one person has insured at high levels, and assume he wins the gamble, the insurance company can still operate with low premiums for their losses are minimal. Thus, "Column" wins the gamble and pays only low premiums. Assume the following utility values as an illustration of the above; higher numbers reflect greater positive utility, lower numbers lesser positive utility. For example, the entries in the matrix located in the upper left-hand corner represents the worst equal outcome for both column and row. The entries in the matrix located in the lower left-hand corner represents the best outcome for row (10), but the worst outcome for column (2).

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<thead>
<tr>
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<th>&quot;Column&quot;</th>
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<td></td>
<td>INSURE AT</td>
<td>INSURE AT</td>
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<tr>
<td></td>
<td>HIGH LEVEL</td>
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<tr>
<td>&quot;Row&quot;</td>
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<tr>
<td>INSURE AT</td>
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<td>HIGH LEVEL</td>
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<tr>
<td>INSURE AT</td>
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<tr>
<td>LOW LEVEL</td>
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Dworkin has not clearly demonstrated why one would choose the cooperative strategy under these conditions. I think Dworkin, like Rawls, believes individuals are not risk takers, and will opt for a guaranteed minimum, over a chance of winning or losing it all. This assumption is highly questionable and a weakness in both Rawls' and Dworkin's theories. If one chooses to insure at a high level, and loses the bet, one then becomes enslaved to his/her maximal earning potential, resulting in the same problem that Dworkin rejected the equal division strategy for—slavery of the talented. Because this is potentially a problem, Dworkin thinks we will reject insuring at high levels.

Furthermore, John Roemer (1985) argues that this insurance strategy does not necessarily make the least talented better-off, but in some cases it can damage the very individuals it was designed to help. Roemer argues in other places (1982a, 1982b) for redistribution of transferable goods within the society, but he believes one should not include non-transferable goods like talent and abilities. If we add talents and abilities to the "distributional pot" Roemer shows that this addition could make the least talented worse-off than when talents and abilities are excluded from the calculations. Roemer's insurance scheme is an expected-utility-maximizing insurance and requires marginal utilities to be equalized both across endowments and across talents.
Given certain utility functions (see figure 1) it will turn out that in order to equalize marginal utilities more resources would be given to the more talented. In this instance the less talented individual would have been better-off under an equal division strategy, than the insurance strategy.

\[ v(R) = u(R, T_1) \quad \text{and} \quad w(R) = u(R, T_2) \]

Figure 1: Distribution of resources equalizing marginal utilities. (Version of Roemer's (1985)figure 2 on p. 176)

This is a serious problem for Dworkin. He has proposed the insurance model as a way to correct the exploitation of the talented, and still provide additional resources for the poorly endowed. The mechanism however, can potentially harm those Dworkin intended to help, the resource poor and the less talented.

Dworkin could respond to this criticism by denying Roemer's interpretation of the insurance model as being an expected-utility-maximizing one. It is clear that Dworkin
operates on a different interpretation, that of a minimal floor insurance model. This minimal floor insurance policy is what I criticized above and believe to be a serious weakness in Dworkin's approach. Dworkin could say that Roemer's criticism is off target because of the difference in interpretation of insurance, but then Dworkin must address the criticism of why this is the proper interpretation of what humans would do in a risk situation. If Dworkin wishes to switch to a maximal-utility-maximizer interpretation then Roemer's criticism is right on target.

Thus, there seem to be serious problems in both Rawls' and Dworkin's arguments for including talent and abilities in the domain of resources to be distributed. What is needed is a positive theory demonstrating why we have ownership over these talents and abilities, and why they should not be viewed as community property. A discussion of such a theory was offered to us by David Gauthier in *Morals by Agreement* (1986). If we can establish such an ownership relationship then it will be clear that talents and abilities should not be included in the domain of resources to be distributed. There is an important distinction between ownership of one's talents and abilities, and ownership or entitlement to the gains gotten from these talents and abilities. I am concerned here with the actual distribution of talents and abilities. I have criticized Rawls and
Dworkin because they have not been clear about this distinction.

Gauthier in *Morals by Agreement* (1986) presents a contractarian theory of morality based upon the works of Hobbes, Locke, and Nozick. I am most interested in his argument for an exclusive right to one's body and powers. Before presenting his argument for the exclusive right to one's body and powers, a few background comments are needed. Gauthier takes the notion of the Lockean proviso, reinterprets it slightly to arrive at an initial bargaining position that is non-coercive. If the proviso, as he interprets it, is respected (in the state of nature) then one can come to the bargaining table untainted by past rights violations and free of the problems created by parasitism and free ridership.

Gauthier begins with the Lockean proviso—that one acquires exclusive title to that with which one mixes one's labor, provided that one uses what one so acquires, and "enough, and as good is left; and more than the yet unprovided could use" (Locke, *Second Treatise*, ch. v. para. 33). Gauthier believes that the key to generating rights to one's body is found in this surplus requirement.

The acquisition of one's body and its powers, the role of labour, and the demand that one put to use what one acquires, will all fall into place, given a suitable reading of the Lockean proviso.
expressed in the words 'enough, and as good', which constrains natural interactions in order to make society possible (Gauthier, 1986 p. 202).

Gauthier follows Nozick in reading the proviso to mean that the situation of others is not worsened. What does it mean to worsen (and, conversely, better) someone's situation? He believes these notions to be unproblematic—"one's situation is better for some person than another, if and only if it affords him a greater expected utility" (p. 203). But in order to apply the proviso one must not only know what it is for a situation to be better or worse than another, one must also identify the base point. The base point, according to Gauthier, is determined by the outcome that you would expect in my absence. If the outcome would be better in my absence, then I have worsened your situation—if your situation is worsened in my absence, then I have bettered your situation. Remember though the proviso only requires that one not better his situation by worsening that of another—it does not require me to make it better. The proviso is to be applied to interactions under the assumptions of individual utility-maximization, rationality, and mutual unconcern. Gauthier uses the proviso to constrain activities which would lay claim to the power of another. His argument is:

Each person, in the absence of his fellows, may expect to use his own powers but not theirs. . . . Continued use of one's own powers in the presence
of others does not in itself better one's situation; use of their powers does better one's own situation. Refraining from the use of one's own powers worsens one's situation; refraining from the use of others' powers fails to better one's situation but does not worsen it. Continued use of one's own powers may fail to better the situation of others but does not in itself worsen their situation; use of others' powers, in interfering with their own use, does worsen their situation. Thus the proviso . . . affords to each the exclusive use of his own (powers) (Gauthier, 1986, p. 209).

Not all worsening of the position of others is prohibited. In order to violate Gauthier's version of the proviso, one must better one's own situation by worsening that of another. The clearest statement of the proviso is: "the proviso prohibits bettering one's situation though interaction which worsens the situation of another" (Gauthier, 1986, p. 205). Thus, if another interferes in the use of my talents and this makes me worse-off (e.g., I can not use my talents solely for my own purposes) and this use of "my talents" makes the other individual better off (e.g., he is able to get a promotion because of something I produced), then the proviso has been violated. Thus, Gauthier's interpretation of the proviso rules out slavery of the talented.

However, the underlying question for me in this section is how is a right to exclusive use (or ownership) of these talents obtained. Rawls and Dworkin want to claim that they are owned by the community; Locke, Nozick, and Gauthier want
to say the possessor of these talents own them. Locke and Nozick simply assume this to be the case—Gauthier provides the argument described above. To determine worsening a base point must be specified. For Gauthier this base point is determined by what a person has or lacks in the absence of others. Thus a right to one's body is based upon the proviso and the physical relationship of talents and abilities to one's body.

Unfortunately, the Gauthier argument cannot do all the work required of it. He needs to show that there are no possible cases in which one uses someone's talents without their agreement, yet does not violate the proviso. Suppose that John is musically talented, but chooses to be a doctor. John, however, creates and hums music while asleep. Mary comes in and tape records these tunes without John's knowledge or permission. Given Gauthier's statement of the proviso this is not an instance of a violation, for Mary has not interfered in John's use of his talents and John is not better-off in Mary's absence. Yet this seems to be a clear case of taking advantage of another's talents. It is the using of another's talents for gain, whether they know or not of such use, that seems to be the problem. Hubin and Lambeth, in a paper entitled "Providing for Rights" (forthcoming in Dialogue) discuss several such counterexamples that cast doubt on the ability of Gauthier's version of the
proviso to ground a person's right to his body and talents.

Where does that leave us with respect to ownership of one's talents and body? There are problems in both Rawls' and Dworkin's arguments for community ownership and problems in Gauthier's argument for individual ownership. I think Gauthier is right however—that we do have exclusive right over our powers, bodies, and talents, and the argument is simple. It seems that what makes a person an individual is a host of factors and properties. One of these factors is what the individual can and cannot do; in fact this defines to a great extent who we are. To treat one's talents and abilities as community property would be to undermine one's self-identity. To drive a wedge between "me" and "my talents" is impossible—because I am not something separable from my body, talents, or powers. If one succeeds in such a separation—i.e., loss of control over one's talents and abilities, what is left is not what we normally think of as an individual.

The argument in this section has examined the domain of social resources to be distributed. I assumed that transferable goods and services are generally thought to be within this domain. I have examined in depth the arguments for the redistribution of gains derived from individual talents and abilities. I have shown that Rawls' and Dworkin's arguments for redistribution are based on
unreasonable assumptions about the ownership of talents. Furthermore, I have shown that the arguments given to redistribute these gains, even if one assumes community ownership, are flawed. We must now turn to a discussion of an alternative principle for the redistribution of these resources.

How much should one receive?

The domain of resources to be distributed includes transferable goods and services, and gains the result of individual talents and abilities. In this section the focus is on what distribution is required by an alternate principle, SWAP. Recall the principle (SWAP):

Justice requires a division of social goods that results in each individual receiving enough goods and services to allow achievement of a satisfactory welfare level; consistent with the most extensive liberty to choose and pursue one's life plan, compatible with a similar freedom for all.

It must be explained why the principle requires only that individuals receive goods sufficient for them to have the opportunity to achieve a satisfactory welfare level rather than goods sufficient to ensure this level. It must also be explained why SWAP employs a satisfactory level rather than requiring, as Rawls does, an outcome that makes the worst-off representative person as well-off as he can be.

What this principle requires is a division of resources that includes equal access to jobs, and is sensitive to
giving each individual the tools he/she requires to meet his/her needs. It should be made clear that an implicit requirement in the principle is that individuals have access to the jobs and professions of society. That is, a just society must not only help prepare an individual for a particular vocation, but must guarantee that once prepared he/she can compete for the job one is prepared to do. This should not be seen as a guarantee of employment, but rather the opportunity for each individual to apply for and receive a job if he/she is qualified.

This principle permits unequal distribution of goods since it will often take more resources for some to have the chance to achieve this level than others, e.g., the handicapped, and those born into lower socioeconomic classes. Consider person P1 who was born very smart and person P2 born mildly mentally retarded. Giving a similar education will not provide each the resources needed to achieve a satisfactory welfare level. Rather what must be done is to provide the resources (even at the cost of unequal means) that each will need. Furthermore a requirement of equal resources fails to meet the requirement since such an interpretation will only perpetuate gross inequalities. The recent examples regarding starting points and discrimination illustrate this problem—offering the same education to both disadvantaged blacks and advantaged whites will not give to
both groups the skills necessary to achieve a satisfactory welfare level. This theory of justice will not simply provide each person with identical commodity bundles, for each individual's basic talents and abilities vary widely.

Additionally, the first half of the principle requires that one have the opportunity to achieve a satisfactory welfare level, not that one actually arrive at it. This is necessary if one takes the equal liberty clause seriously. For example, suppose the requirement is not for an opportunity to achieve the satisfactory welfare level, but for some equal and basic welfare level. Assume that Sam likes to gamble so much that he takes his resources (education, health care vouchers) and cashes them in on the black market. Sam proceeds (as you can probably guess) to lose all the money. This principle would not require an additional allotment of resources to Sam, instead such additional resources should be seen as not required by justice (4). To see why this would be so I must turn to a discussion of the equal liberty clause.

Consider the second half of SWAP—the most extensive freedom to choose and pursue one's life goals, compatible with a similar freedom for all. A discussion of this clause is required to appreciate fully why justice need only provide enough goods and services (broadly construed to include...
opportunities for jobs and positions within the society) to achieve a satisfactory welfare level and not an equal welfare level. By the freedom to choose and pursue a life goal I simply mean that individuals are able to consider their talents and abilities and decide for themselves what is the good life. The state should be neutral with respect to what this good life is, providing the framework for its members to so choose. This choice requires that it be done against a backdrop of self-knowledge, with respect to one's talents, abilities, and preferences. The idea is this—individuals are born with a finite number of abilities and talents. One's choice of a life goal will be influenced by the beliefs one has about his own talents and abilities. Part of what is required in the services available to individuals, is assistance with knowing one's own talents and abilities. If you continually fail to get a successful match, then you are responsible for such failures and must pay the cost of such choices. For example, suppose that you want to be a classical musician yet you are tone deaf. The principle requires only that it provide you with the goods and services needed to achieve a satisfactory welfare level, given your present talents and abilities, not the opportunity to be a great musician.

Having the freedom to choose a particular path must include paying the cost of such a choice. Otherwise the
freedom would be in jeopardy of being lost. Return to the gambler example. Having the freedom to gamble means that one can risk money in hopes of winning more money but part of this game includes the risk of losing. If this risk is removed, so that one no longer can lose but only win the game, the game has been fundamentally changed, since part of the game includes the risk. Furthermore, if the loser is reimbursed his losing amount by the winner, then there really is no winner and the game folds. Gambling is no longer an option. In order for the gambler to have the freedom to play and to win, he must pay the price for his choice. If he wins the gamble, he keeps the winnings, if he loses the gamble he suffers the loss. If the winner of the lottery is forced to split his winnings with all the losers, then soon no one will have the option of gambling because there is no incentive to play. This example illustrates the fundamental issue. By intervening and not making one pay the cost of a risk when one loses, one's freedom of choice is jeopardized. For if we take away the risk, either through subsidies or paternalistic legislation, one will lose the freedom to choose.

We can see that the most a theory of justice should require is that each individual have an opportunity to achieve a satisfactory welfare level, not that he actually
achieve it. If I choose to lead my life in such a way that I gamble with my basic resource allotment then either I accept the cost of making this choice or I accept some restrictions in my freedom. It would seem then that the following options are open:

i) if I lose, I am forced to pay the cost, i.e., lack some basic necessity;

ii) if I lose, I can be allotted further resources but only at the cost of either reducing my freedom to choose and pursue (I will no longer have the option of gambling) my life goals and/or forcing others to pay the cost of my gamble, thus interfering unjustly in their lives;

iii) if I win, I get to keep these additional gains;

iv) if I win, I will be forced to share my winnings.

My claim is that a principle of justice that is to be consistent with the equal liberties clause must hold individuals responsible for their decisions and if they gamble and lose, they will have to pay. This will mean that even though people may end up living in poor conditions because of their choices no violation of justice has occurred.

An objection to this line of reasoning may be raised—what has basically been outlined is a justification for not providing additional resources when there has been some change in one's status with respect to the basic welfare level. There do however seem to be instances where
additional resources are justified when such a change has occurred. This is so because one's position changes and what provides an opportunity at T1, may not at time T2. For example, Judy has what she requires to achieve the basic welfare level, i.e., a job paying enough to meet her needs, she is satisfied with the work, etc., but suddenly she goes blind. Does the principle of justice require different treatment for Judy than Sam (the gambler)? Drawing on a distinction that Dworkin makes in "Equality of Resources" (1981b) I think the answer must be yes. Dworkin makes the following distinction between option 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. Brute luck is a matter of how risks fall out that are not in that sense deliberate gambles (p.293).

In the gambling example it is obvious that the results of this situation have to do with option luck, and the situation could have been predictably avoided if the gambler had chosen otherwise. However, the second example, the blind individual, can be seen as an instance of brute luck, for which the person is not responsible. Not providing this individual with further resources would be unjust because she has failed to be given the resources required by the principle. Even though the blindness, in a very serious
sense, reduces one's freedom to choose, this restriction occurs because of a "natural" process, uncontrollable by man.

The satisfactory welfare level

The principle requires only that one has the resources necessary to achieve a satisfactory welfare level. A good deal depends upon how this level is interpreted for it directly affects the amount of resources that must be provided. I have an uncomplicated notion of what this amounts to, that is a level in which one's physical and basic psychological needs are met, i.e., enough food for a healthy subsistence, shelter, clothing, and the psychological support and environment to achieve self-esteem, so that individuals can pursue their life plans. The resources required to meet such a requirement will be relative to a society's development. This is because meeting a person's psychological needs are tied into an individual's notion of self and self-respect, and the power structure and the place one has in that structure influences directly the success of meeting this need. What is a satisfactory welfare level in one society may not be so in another society. Hence my claim is that justice requires at least this much—that every individual have the resources necessary to achieve a satisfactory welfare level. This notion does not include a preference
satisfaction requirement. The distribution one is entitled
to under this principle will recognize differences in native
talent and abilities, but will not justify an increased
share of the social pie because of one's preferences.

This principle requires **only** the resources and services
to achieve a satisfactory welfare level, **not** an equal or
equal minimal welfare level. This is because since part of
what is required by a theory of distributive justice is that
it can handle some considerations of merit, desert, as well
as guaranteeing fair rules of cooperation. Consider two
individuals, Bob and John who both have the opportunity to
achieve a satisfactory welfare level. Both Bob and John have
jobs at the local factory producing widgets. They are both
able to produce 50 widgets a week. Bob, but not John,
decides to work an extra two hours each day. Bob, given his
extra hours is able to produce an additional 10 widgets a
week. Who should benefit from this additional production?
Since John has had the opportunity to work the extra hours,
but has preferred his leisure time over further production,
it seems that he has no claim over any portion of the 10
widgets. The reason we must not force redistribution of
Bob's additional 10 widgets has to do with the equal liberties
requirement. The equal liberties clause requires that
one pay the full cost of one's choices if he is to have the
freedom to choose and pursue his life goals. By giving
John some of the additional income we no longer hold him accountable for his choices. Not only does John get the leisure time, but he gets part of the widgets produced by Bob. One escape from this is to assume that either both or neither must work the overtime, but this seems also to be at odds with the liberties principle. Such restrictions limit too severely one's freedom to choose and pursue one's life work. Additionally, if a division required Bob to give John a portion of his earnings from the extra work, many have claimed that there would be little incentive for individuals to produce the extra ten widgets.

Thus, anything more than a satisfactory welfare level is a problem because:

i) if the societal resources produced over the amounts needed to meet the satisfactory level are divided in such a way that they reward individuals who have not produced these resources, then the liberty of the individuals are interfered with—both Bob and John are being interfered with—John is not being held responsible for his choices, and Bob is being forced to subsidize John's leisure;

ii) there will be little incentive to work longer hours (other than the satisfaction gotten by working itself!).  It seems clear that redistribution beyond what is required to achieve a satisfactory welfare level is unjust. Once
individuals have had the resources (including goods, services, opportunities) to achieve a satisfactory welfare level, justice requires no further redistribution.

A Justification for the Satisfactory Welfare Achievement Principle

In the previous parts of this section the focus has been on explaining SWAP. Our attention must now turn to exploring the reasons for accepting SWAP as the preferred principle for a just distribution. The justification consists of two arguments which provide two separate and independent reasons for accepting SWAP, specifically aimed at different audiences, the libertarians and the social contractarians. The argument aimed at the libertarian has been loosely stated in Section I of this chapter. I will restate this argument and give reasons why the libertarian should accept SWAP. Second, because I am specifically concerned with addressing the contractarians, I argue within a contractarian framework, i.e., Rawls'. I show that SWAP would be the principle chosen by a rational individual in a Rawlsian original position.

The libertarians (e.g., Nozick) have argued against a redistribution of wealth claiming that such redistribution is a violation of one's rights except in cases where redistribution is required to rectify past injustices. The
only justifiable constraints on the market are controls to protect against theft and fraud. Entitlement to property is established by repeated applications of the principle of justice in acquisition and the principle of justice in transfer. The principle of justice in acquisition requires (for Nozick) that appropriations of unowned resources can occur only if there are no (Lockean) proviso violations. My claim here is that redistribution guided by SWAP will decrease the probability that there are net losers and proviso violations. Nozick argues that a proviso violation has occurred if the condition of some individual is worsened by a particular appropriation. However one is not worsened simply by the loss of opportunity to appropriate that or any property, rather worsening occurs in those instances where the appropriation leaves one with fewer life prospects. To prevent this Nozick argues that the appropriation must improve the social conditions and opportunities of those harmed by the appropriation. This implies that those harmed by the appropriation must be able to avail themselves of the improved social conditions and the increased opportunities. To ensure that this occurs individuals must have access to the resources and services required to take advantage of these new conditions and opportunities. Nozick recognizes this point also when he states that the net losers, those who have lost because of civilization, need to receive a
socially guaranteed minimum (p. 179). These net losers may still be losers after they receive the guaranteed minimum, but by guaranteeing the minimum we have increased the chances of these individuals to "win" within the social framework. To reduce the probability of having proviso violations and net losers within the society a principle of redistribution is needed.

SWAP meets these required conditions. First of all it guarantees a social minimum. Second, by requiring the services necessary to take advantage of different (and arguably increased) opportunities it reduces the probability of having proviso violations. Furthermore, since SWAP holds individuals responsible for their choices and does not shift the burden of these costs to others SWAP should be endorsed by the libertarian. SWAP provides a mechanism for the libertarian to guarantee that the principle of justice in acquisition can be met. Without such a principle the libertarians' claim to private property will be unfounded.

Moreover, there are good reasons to show that SWAP is the preferred end-result principle of justice. To show this I must make clear why SWAP would be chosen over other end-result principles, specifically the principles advocated by Dworkin and Rawls. I will use the Rawlsian framework of justification to show that SWAP would be chosen over both
Rawls' and Dworkin's principles. Rawls argues that his principles of justice are the correct principles because they account for our considered moral judgments about what is just or unjust better than other principles (for Rawls, this is utilitarianism) and because they would be chosen in a situation appropriate for choosing principles of justice.

The first justification offered by Rawls contends that his principles account better for our considered judgments about what is just and unjust. But this method of justification is convincing only to those who share Rawls' judgments. I would argue that SWAP accounts better for our considered moral judgments for it has the advantages of the Rawlsian principles, i.e., provides for equal liberty, yet improves on Rawls' principles because it accounts for individual responsibility and desert better than Rawls' theory. SWAP recognizes human beings as risk takers who are responsible for the cost of their gambles, and also recognizes that individuals want some protection if they end up in the worst-off position in society. SWAP does this because it is an insurance strategy that guarantees a minimum floor, and may permit one to gain unconditionally from his own efforts. But both of these appeals to considered moral judgments have little, if any, justificatory force. All that can be said is that one either shares or disagrees with these considered moral judgments. More is
needed to convince us that Rawls' principles or SWAP would be chosen from the original position.

Rawls offers a second justification for his principles—that these would be the principles chosen under specified conditions deemed appropriate for such choosing. He argues that his principles of justice will be chosen when: 1) the individuals are in the original position, and 2) they choose as though their enemy will select their place in society. The Rawlsian original position conceives of individuals as being motivated to pursue their life plans in a rational way. Each person is conceived as being mutually disinterested with a desire to acquire as large a share of primary goods as possible. The parties in the original position are subject to informational constraints described by Rawls as the veil of ignorance.

The principles of justice are chosen behind a veil of ignorance. This ensures that no one is advantaged or disadvantaged in the choice of principles by the outcome of natural chance or the contingency of social circumstances. Since all are similarly situated and no one is able to design principles to favor his particular condition, the principles of justice are the result of a fair agreement or bargain (Rawls, 1971, p. 12).

Moreover, the principles chosen in the original position must satisfy certain formal constraints. These are; generality, universality, publicizable, able to impose order on conflicting claims, and finality.
Assuming these conditions Rawls argues that the rational solution is to use the maximin rule to select the principles of justice. The focus here is to show the maximin rule would not be the rational choice, but that an insurance strategy is preferred. But even if one grants to Rawls the maximin strategy he has failed to give a convincing argument for the choice of the difference principle. As discussed earlier, the difference principle exceeds the demands of justice since it is implausible to argue that justice requires maximizing the minimum, where the minimum is at a generous level.

Rawls suggests three features of the situation that give plausibility that those in the original position will select the maximin strategy (1971, p. 154). First, all probabilities are unknown. The veil of ignorance excludes all knowledge of particular likelihoods. The parties in the original position have no basis for determining the probable nature of their society. Second, "the person choosing has a conception of the good such that he cares very little, if anything, for what he might gain above the minimum stipend" (p. 154). . ."if we can maintain that these principles provide a workable theory of social justice, and that they are compatible with reasonable demands of efficiency, then this conception guarantees a satisfactory minimum" (p.156).
Third, the rejected alternatives (e.g., utilitarianism) have outcomes that are intolerable. But these considerations are unsuccessful in establishing Rawls' claim that maximin is the choice strategy for those in the original position (see Hare, 1973; Hubin, 1980; and Buchanan, 1980). In fact, Rawls' considerations provide a better justification for an insurance strategy, than they do for the maximin rule.

The first consideration or feature is that the probabilities are unknown. Even though this feature is questionable, maximin is not the only solution. Many other solutions are possible to the problem of decisions under uncertainty (e.g., maximax, the minimax regret rule). The insurance strategy, and specifically SWAP, fares no better or no worse than maximin on this point. The second feature is that of decreasing marginal utilities. As Hubin and Buchanan have pointed out this is an implausible feature of this situation. If we are at a level that additional resources have only marginal utility we must be at such a high level of resource production and possession that resources are not moderately scarce (Hubin, 1980). Further this assumption is at odds with Rawls' basic thesis that the possibility of gains above the minimum will serve as incentives for greater achievement (Buchanan, 1980, p. 28). But if in fact the people in the original position only wished to gain a minimum stipend, then an insurance strategy is
more plausible than maximin. Finally, Rawls claims that some outcomes are intolerable and that maximin is the only strategy that will guarantee the required minimum. But this is surely false. Assuming that such a minimum can be guaranteed, (i.e., operating within conditions of moderate scarcity as does Rawls) there are many principles which lead to the satisfaction of the required minimum, including SWAP.

However simply showing that these features are unsuccessful in supporting the maximin rule and weakly supportive of an insurance strategy is inadequate to demonstrate my claim that an insurance strategy (and specifically SWAP) would be chosen in the original position. I need to show that rational, self-interested maximizers find an insurance strategy more reasonable than the maximin rule. It is obvious that individuals in the original position will be concerned about the worst-off representative person position. My disagreement with Rawls is about how much protection we would choose for this position. Rawls claims that we would make it the best it can be—while I argue we would opt only for a guarantee of the resources required to achieve a minimum. What Rawls fails to see is that the difference principle chosen using the maximin rule will force those better-off to pay the costs of choices of individuals in the worst-off position and interferes with
the freedom of the better-off individuals. But more impor-
tantly, this strategy also interferes with the freedom of the worst-off individuals. If others are forced to pay the cost of the worst-off individual's gambles, it is highly likely that paternalistic decisions will restrict the choices of this group. Individuals in the original position wish to have the freedom to choose their own life plans, yet the difference principle will permit unjustifiable interference with the choice for both those that are least and better advantaged. But if this is the consequence of adopting the difference principle then according to Rawls' full theory the difference principle will not come into play. If adopting the difference principle would lead to interference in individual liberty (and there are good reasons to suggest this result) then Rawls' theory is immune to this criticism because of the ordering of his principles. This may save the conceptual integrity of the theory, but the end result is that the difference principle would be a useless principle.

Additionally, the insurance strategy resolves situations which provide for the same floor, but with different payoffs in other circumstances, in a more plausible way than Rawls' lexical ordering principle. Consider the following matrix.
Rawls' principles will choose d4 since the second worst-off person is better in d4 than in all other decisions. But if 5 units provides a satisfactory minimum, why not choose d1, where there is a chance of doing much better in two of four circumstances. I think most would choose d1 over d4 and not maximize the worst-off (in this case the second worst-off) position, but rather choose to protect the floor, with a chance to do much better. Further, assume that 3 units successfully meets the minimum requirement, then d2 seems to be the rational choice. The difference principle requires that any improvement in one's position must bring about a bettering of the situation of the worst-off group. It seems highly questionable that if the welfare of the group is at a satisfactory welfare level that most would see it just that improvement in other groups must still benefit this worst-off representative person. As Hare has stated: "I have no inclination to maximin, once the acceptable minimum is assured; after that point I feel inclined to take chances in hopes of maximizing my expectation of welfare" (1973, p. 249).
Thus, the rational choice for individuals in the original position is to choose an insurance strategy guaranteeing a minimum floor. Protection from utter calamity and the opportunity to improve one's welfare without restrictions if the least-advantaged have an insured minimum are reasons in favor of the insurance strategy. What still needs to be shown is that SWAP would be the preferred insurance principle. SWAP incorporates the equal liberties requirement of the Rawlsian principle so that these advantages are retained. The advantage of SWAP over other insurance strategies, e.g., one that guarantees a minimum of resources, is that SWAP takes into account one's responsibility for one's actions. SWAP gives us a rational limit for assistance—set at the services and resources needed to achieve a satisfactory welfare level. SWAP is the rational choice by individuals who are rational, self-interested maximizers because it has the advantage of protecting those at the bottom and protecting those better-off who may benefit by their own efforts without necessarily improving the conditions of the worst-off representative person. If the least-advantaged is such because of voluntary choices, then SWAP requires nothing more.

Moreover, a minimum floor is justifiable, not simply on grounds of redress for past injustices or because it would be the chosen strategy in the original position, but
because those better-off within the society must pay the full cost of their success. Since ownership of private property requires compensation to those denied its use (in most circumstances) and because one is never completely entitled to the gains gotten from one's talents and abilities in a social setting payment is required to those worse-off.

Furthermore, this insurance strategy is quite different from the one suggested by Dworkin and discussed earlier. Dworkin argues that resources should be distributed equally via an auction that meets a no envy requirement. He develops his theory independent of the Rawlsian original position, so these conditions do not apply to the choice situation. His insurance strategy is used simply to equalize the talents within the society, not as a complete strategy for determining a principle of justice. SWAP differs significantly from Dworkin's position in that SWAP has no requirement for equalizing resources.

Thus, SWAP is the rational principle for guiding a just distribution. It is superior to Rawls' principles since it accounts for individual responsibility and desert in ways that Rawls' principles do not. It improves on Dworkin's theory since there is no equal division required, rather an amount necessary for each individual to achieve a satisfactory welfare level. Furthermore SWAP should be
adopted by the libertarian since it increases the probability that the conditions of the principle of justice in acquisition are met.

In summary, this section has offered a new principle for the distribution of resources within a society. The principle requires that a just society ensure all individuals the resources (understood as goods, services, opportunities) to achieve a satisfactory welfare level, consistent with a strong liberties principle. This principle is different from Rawls' principle since it does not require a particular outcome. To evaluate the distribution within a society one must know what resources an individual has had to work with in the past. In this way the principle resembles the Nozickean theory. The principle requires only that one have the resources to achieve a satisfactory welfare level, not that he actually attain it. Finally, a justification was given demonstrating that SWAP would be chosen by a rational, self-interested maximizer behind the veil of ignorance.

Summary

This chapter has examined recent theories of justice offered by Nozick, Rawls, Gauthier, and Dworkin. Each of these theories are insightful, yet problematic. The libertarian theories are flawed since they fail to establish the strong property rights in natural resources, and in man-made
commodities within a social framework, that is required. They do not recognize that the establishment of property rights in a social framework is clearly different from the establishment of property rights in a state-of-nature. Other theories of justice have often been too quick to disintegrate the person by claiming that one's talents and abilities are community property. The reason for this error has been a confusion between establishing a right to one's talents/abilities and establishing a right to the gains generated from these talents. Furthermore, many theories have failed to hold individuals accountable for their decisions and gambles. The theory described in section II improves on these theories. It can be seen as a blending of the theories of Nozick, Rawls, Gauthier, and Dworkin. Furthermore, I have given independent arguments that show why SWAP should be accepted by the libertarians and the preferred principle of social contractarians.

SWAP will be used in Chapter Five to argue for a particular distribution of health care services. However, even though we now have a principle to decide redistribution, we do not know the domain of services to which it applies. In the next chapter I consider this difficult issue of identifying a health care service. Are health care services simply all services offered by a health care
professional or is it more limited than this? I will argue that a health care service is a service to insure one's health or freedom from disease. Other services offered by a health care professional that falls outside this domain are not justified by arguments given in this discussion.
Chapter IV

An Analysis of Health and Disease

Introduction

There is a wide range of services offered by the present health care delivery system—from life-saving treatments (e.g., removal of a malignant growth), to health maintenance and promotion services, (e.g., well-baby care, prenatal visits), to services that meet some personal wish (e.g., breast reduction). To determine which services ought to be provided to the members of a just society, what constitutes a health care service needs to be clarified. This clarification is not easy since the classification of a certain service as a health care service, rather than some other social service, depends on the interpretation of the concepts of health and disease. This chapter focuses on the issue of health and disease. As we will see, this issue is more difficult than it might initially appear. To illustrate this point consider the following descriptions.

M.N., aet. 17; admitted into the London Surgical Home September 4, 1861.

History.—Was perfectly well up to the age of fifteen, when she went to a boarding-school in the West of England. In the course of three or four months she became subject to all symptoms of hysteria, and from that time gradually got worse, having fits, at first mild in character and of rare occurrence, but gradually more severe and
frequent, till she became a confirmed cataleptic. For several months before admission, she had been attacked with as many as four or five fits a day, and during the whole journey from the North of England to London she was unconscious and rigidly cataleptic. She was seen immediately on arrival, and there was no doubt that it was a genuine case of this disease. So sensitive was she, that if any one merely touched her bed, or walked across the room she would immediately be thrown into the cataleptic state.

Before making any personal examination, Mr. Brown ascertained both from her mother and herself, that she had long indulged in self-excitation of the clitoris, having first been taught by a school-fellow. The commencement of her illness corresponded exactly with the origin of its cause; in fact, cause and effect were here so perfectly manifested, that it hardly wanted anything more than the history to enable one to form a correct diagnosis. All the other symptoms attending these cases were, however, well marked.

The next day after admission she was operated upon, and from that date she never had a fit. She remained in the Home for several weeks. Five weeks after operation, she walked all over Westminster Abbey, whereas for quite a year and a half before treatment, she had been incapable of the slightest exertion.

The young woman was successfully diagnosed and treated (reprinted in Englehardt, The Foundations of Bioethics, 1986 pp. 160-161).

What was it about this condition that made the physicians of the time so certain of their diagnosis and treatment? What conceptualization of disease permitted such conclusions?

Consider one further example.

Drapetomania is unknown to our medical authorities, although its diagnostic symptom, the absconding from service, is well known to our planters and overseers, ... The cause (of drapetomania), in most of the cases, that induces the negro to run
away from service, is as much a disease of the mind as any other species of mental alienation, and much more curable, as a general rule (Cartwright, 1981, p. 318-319).

In both instances the definition/analysis of disease is strongly influenced by the societal values. In fact, the conception of disease operating within these examples requires that at its core, disease/health recognition is directly dependent upon the values held within that society. This view, the normative model, is one which is strongly value-laden. To quote Caroline Whitbock:

"to use these terms is to say that that to which they are applied is good, or bad, valuable or worthless, in some way—-aesthetically, ethically, religiously, epistemically, or hedonistically (1981, p.614).

An alternative conception, the naturalistic model, of disease and health has been discussed by many including Christopher Boorse (1975, 1976, 1977, 1983), Leon Kass (1975) and Thomas Szasz (1978). On this account, health and disease are value-free concepts that describe states that individuals are in, but do not primarily evaluate these states. What is disease/health turns on a functional analysis in biology and the account given of disease applies across species.

I am concerned in this chapter with the answer to the ontological question, 'What is disease and health?' because the answer to this question is crucial in identifying the
set of services that should be available in a just system. My claim is that the first limitation on the set of health care services that should be available because of considerations of justice is to services that treat disease, and promote and maintain health. (This set of services is further restricted in Chapter Five.) To answer this question I examine the adequacy of the naturalistic and normative models as answers to this question. Any adequate answer should classify conditions that are clear and uncontroversial cases of disease as disease, e.g., pneumonia and leukemia, and should not classify conditions clearly seen as normal as disease. An adequate analysis should agree with our pretheoretical notions of disease and health.

I find both the normative and naturalistic models to be inadequate answers, albeit for different reasons. The normative model is wholly unacceptable as an answer to this question, while the naturalistic model is acceptable with a few revisions.

The Normative Answer

The normative model's definition or analysis of disease is intimately tied to the values held within the society. Most philosophers who put forth this model of health and disease believe that there is a normative and nonnormative component to these concepts, but that the latter is subordinate to the former. The secondary notion is a descriptive or
explanatory notion of disease/health. To call someone diseased is to claim that he is in an undesirable or bad state, and to give some factual information about that individual. It is analogous to claiming that an individual is ugly—not only are we stating that he/she is in an undesirable state—but we are giving some factual information about that individual. Martha Rogers (1980) sees health and illness as value words, broadly defined by each culture to denote behaviors that are of high value or low value to that society and Lester King (1954) in "What is Disease?" states that diseases are culturally defined by the values held within a society. To use his example, the seeing of visions in some communities is considered a reason for special honor; in our society, it is considered a sign of a diseased state. In this case the same set of observables is recognized as a diseased state in one culture, and in another culture a state to be sought after and desired. A crucial and fundamental question is how is a set of observables determined to be either a diseased state or a healthy state. King believes that what is a disease depends upon the values of the society. Peter Sedgwick (1981) claims that all sickness, whether physical or psychological, is essentially deviancy.

Children and cattle may fall ill, have diseases, and seem as sick; but who has ever imagined that spiders or lizards can be sick or diseased? Plant-disease may strike at tulips,
turnips, or such prized features of the natural landscape as elm trees; but if some plant-species in which man had no interest (a desert grass, let us say) were to be attacked by a fungus or parasite, we should speak not of a disease, but merely of the competition between two species. The medical enterprise is from its inception value-loaded; it is not simply an applied biology, but a biology applied in accordance with the dictates of social interest (Sedgwick, 1981, p. 121-122).

Sedgwick has presented an analysis of disease that is intimately tied to human interests but he is wrong in stating that the identification of disease is tied to our interest. Human interests define what diseases we care about perhaps, but not what states are diseases (at least not in the simple way he supposes).

These are clear examples of individuals who argue that values play a major role in what is a disease. As H. Tristram Engelhardt (1976) states:

even if the structure of a disease explanation may be fairly value free, the fact that they are disease explanations will turn on whatever values cause us to identify certain states of affairs as illnesses, that is, as proper to be explained as diseases (p.262).

Engelhardt is very clear that values pick out what we call an illness, and that from this judgment a disease will be identified. Engelhardt claims that value judgments are at the core of our language of health and disease. 'Disease' is a theoretical construct used to explain a pattern of phenomena in order to understand the etiologies, and predict and alter the outcome.
Engelhardt offers three reasons for identifying a state of affairs or pattern of phenomena as one that requires a disease explanation. They are:

(1) ideologies cause us to explain a pattern as disease in order to fit our ideological needs;

(2) conditions which we want to treat like an illness, even if there are not clear indications that this is appropriate, e.g., we choose to call alcohol and drug abuse a disease so that these individuals can be treated in a certain way;

(3) the phenomena meet the following criteria.

(a) i. The pattern is one that we find to be unpleasant, disagreeable, or distressing; or

ii. the pattern is related to a known disease pattern, yet asymptomatic (e.g., finding a solitary nodule on a routine chest film—we know through a disease explanation that the presence of this nodule is part of a pattern that eventually becomes unpleasant, disagreeable, or distressing); and

(b) this suffering is due to some dysfunction of our bodies and/or minds (and according to Engelhardt this is where values come into play); and

(c) the pain and suffering is not the "immediate outcome of circumstances which are the subject of free
choice. They must result from psychological or physiological laws" (Engelhardt, 1981, p.41).

Values are essential in determining what conditions are health or disease because value judgments determine what is normal or abnormal function. Disease states are identified based upon judgments bearing on what functions are proper to humans, or because of pain, even if this pain is not dysfunctional, or because of judgments concerning human disfigurement and deformity. The judgments single out states of affairs—patterns of phenomena—to be explained as abnormal physiological or psychological processes rather than normal or proper processes. The underlying decision about what is normal is not something which can be read off a species design but is a value judgment. Since what is a disease is basically what is abnormal as determined by value judgments, then what counts as disease is essentially determined by a value judgment.

In addition to the role values play in disease definition, Engelhardt claims:

Choosing to call a set of phenomena a disease involves a commitment to medical intervention, the assignment of the sick role, and the enlistment in action of health professionals (Engelhardt, 1981, p.41).

Thus, once something is recognized as disease then treatment must follow.
In sum, the normative model as explicated by Engelhardt appears to answer the question, 'what is health and disease?', by giving several reasons for classifying a set of phenomena as a disease. All of these reasons share the characteristic that they are essentially value judgments. Moreover, once a pattern of phenomena is labelled disease, the diseased individual is viewed differently.

R.M. Hare (1986) also argues that health and disease are normative concepts. Hare argues that one of the standard constituents of the notion of disease is that in general the condition is bad for the individual. "(W)e seem to classify conditions as disease if and only if they are bad things for the patient, in general" (p. 178). Furthermore, Hare endorses the entailment relationship between disease and treatment. That is, if a condition is determined to be a disease, then other things being equal, we ought to treat it.

Hare's model of disease is the following:

A (a person) exhibits observable features F...F
So A has a condition C.
But C is a disease
So A is not healthy
But T is the treatment most likely to remove C
So A ought to be given T (p.179).

Hare argues that premise three is the first value-judgment in the inference and that it makes a difference as to whose evaluation it is. In most instances Hare argues that the
evaluation must be done from the patient's perception—that is the patient determines if a particular condition is a disease. However, in some instances, e.g., schizophrenia, the evaluation is better made by the appropriately trained physician.

Before evaluating the adequacy of the normative model in general, a few critical comments about Hare's model are needed. Hare argues that his model will successfully avoid classing political deviants as disease:

The patient in (the political deviancy example) will not agree that political deviancy is a disease, because he will not agree with the evaluation of members of the regimen who so label it. So the psychiatrists will be doing wrong to try to 'cure' it against the patient's wishes; it will be a breach of another principle, that of political freedom, to which we all attach importance (Hare, 1986, p. 180).

Why isn't this a case in which the patient does not know best, as the schizophrenic example? I think because we see schizophrenics as diseased and political dissidents as not. Hare seems to beg the question—schizophrenia is a disease because the psychiatrist say so, even though the patient may not see it as bad; political dissidents are not diseased because only the state sees the condition as bad and their evaluations do not count here. I think Hare is wrong, we allow a psychiatrist to make judgments about the individual because he is diseased, not vice versa. Furthermore,
political dissidents are not diseased, thus no one can legitimately speak for these individuals.

The Adequacy of the Normative Answer

I will argue in this section that the normative model is inadequate as an answer to the ontological question. Those defending the normative model are confused on the question being addressed and their confusion leads to unacceptable consequences. This model has primarily been associated with discussions in the philosophy of medicine, with an underlying assumption being that whatever physicians do it must necessarily be connected with disease. In fact one of Engelhardt's criticisms of Christopher Boorse's account of disease is that it is inadequate because it does not give:

an adequate reconstruction or account of the ways in which patients and physicians understand disease. . .It is because medicine is applied to the achievement of particular individual and societal goals that Boorse's attempt must fail (Engelhardt, 1986, p. 171).

Engelhardt implies that an adequate model of disease for clinical medicine must account for these individual and societal goals, and by virtue of his task the definition of disease must also be defining of medicine. The normative model thus is answering not the ontological question, but a practical question of the domain of medicine and nursing. Moreover, since this model ties together disease treatment
and disease identification, this model attempts to answer a third prescriptive question, 'what ought we treat?'. However, it is because this model's blurs together as one these three distinct questions that it ultimately fails to address adequately the ontological question. It may be, though it is not my concern here to either prove or disprove, an adequate answer to the domain and treatment questions.

The normative model does take into account individual and societal goals, and by so doing focuses on the practical question and not the ontological one. Philosophers of medicine have consistently defined the physician's domain of concern as health and/or disease (5). Nurse theorists (including Nightengale, Peplau, Roy, Neuman, Rogers, Parse) have agreed that the domain of concern for nursing is defined by health (6). In order to legitimate nursing and medicine's involvement in treating a variety of conditions the definitions have necessarily been vague. Many conditions have been included as health and/or disease simply to legitimate practitioners' involvement in these conditions and the conceptualization of health and disease within the normative model has allowed such expansion. For example, the World Health Organization claims that health is "a state of complete physical, mental, and social well-being and not merely absence of disease or infirmity" (7). This comes very
close to equating health with happiness. Having this as the end or goal of the health care professions seems to permit health care professionals license to intervene in all sorts of activities in their professional role. On this account it seems as though the domain of concern is expanded to any disorder which may interfere with human happiness. Moreover, such definitions of health blur the distinction between health and other valuable human states.

Leon R. Kass (1975) in his article, "Regarding the End of Medicine and the Pursuit of Health," voices these same concerns. Happiness should not be the goal of the health care professions. Interventions done simply to respond to the wishes of one's clients, e.g., performing sterilizations, cosmetic surgeries (not aimed to correct acquired or inborn deformities), should be recognized not as acts to improve health, but to satisfy other personal desires. Moreover, as technology has been developed that gives us the ability to alter human behavior, health care professionals have become involved in modifying, or assisting their clients in modifying behavior. As practitioners have moved into this realm the definition of health and disease has been broadened to accommodate conditions society or individuals wish to alter. In order to curb criminal or antisocial behavior, or to "prevent" homosexuality, society has
needed a legitimate means for intervention to achieve its desired outcomes. Since medicine and in some instances nursing are the only professions legally entitled to intervene and alter the functioning of the human body and brain, their skills have been subverted for social causes. Numerous examples from the history of medicine illustrate the point. Drapetomania, discussed in the first part of this chapter is one such example. Other examples include the treating of political dissidents as mentally ill; classifying homosexuality or masturbation as a disease. A recent debate regarding the status of premenstrual syndrome has emerged. Is this yet another instance of a condition being recognized solely for social reasons? (8)

The definition of disease and health has been expanded to permit health care professionals intervention in non-disease and non-health related conditions. Such usage has caused confusion in determining what is health and disease. This confusion stems from a conceptual error that medicine and/or nursing should be involved only in health and disease matters and this belief results in a broadening of the definitions to include any condition they wish to treat. There is a serious and pragmatic concern raised by the error, i.e., once conditions get labelled as diseases, an implicit approval for treatment seems to follow. The fundamental question of whether a behavior should be altered is
never raised.

Engelhardt's and Hare's analysis joins together treatment and disease identification. Recall Engelhardt's claim, "choosing to call a set of phenomena a disease involves a commitment to medical intervention,. . . (1981, p. 41)". This relationship between disease and disease treatment has serious consequences for activities health care professionals (especially nursing and medicine) are engaged in, for many seem to be activities unrelated to health and/or disease. Birth control counselling, sterilizations, cosmetic surgeries, all have more to do with satisfying clients' desires, than maintaining their health and freedom from disease. The normative model, at least as discussed by Engelhardt, seems to endorse a reciprocal entailment between disease and treatment, i.e., if disease, then treatment should follow and if treatment is needed or desired, then the condition is a disease.

Engelhardt holds this view because he believes that values must be used to determine what is functional within the human species. He argues that there can be no absolute standard with regard to the human being for there is no species design. In contrast to Leon Kass (1975) and Boorse (1975, 1976, 1977, 1983), he argues that, "there is simply not a single excellence or unambiguous function to be played
by all the individuals of the species" (Engelhardt, 1979, p. 264). He believes that one can escape the use of value judgments in health and disease language:

only if (1) one defines diseases as departures from the usual physiological and psychological functions of members of particular species or (2) one accepts a species survival as the goal. Otherwise, what counts as disease counts so not because of the designs of nature but because of our goals and expectations (Engelhardt, 1979, p. 264).

Engelhardt believes that health and disease language is used to evaluate the success or failure of an individual to meet a particular norm and that we should be unwilling to accept a species design analysis of function because this disregards the suffering of humans. Engelhardt seems to hold that one of the most crucial criterion in defining disease is its relationship to human suffering and the notion of a human function being what is typical of the species must be avoided and replaced with a notion of function defined by our values. Thus it would seem that what is dysfunctional will not turn on whether the process is doing what is expected for the species, but rather what is valued or disvalued in the society. And for Hare since disease is necessarily tied to what is bad we must do all that we can to remove the condition.

This is precisely the problem with the normative model. Because this model links human suffering to the
identification of disease, confusion arises about what is
disease and its relationship to treatment. This link occurs
at the level of identifying norms, and dysfunctional states
for humans. Human suffering, because of its disvalue, is
dysfunctional. If we choose a model that disregards human
suffering as definitive of disease we are callous and insen­sitive, for being a disease is a necessary condition for
treatment. However, this is incorrect. It is only when we
tie treatment and intervention to diseases that this must
occur. By limiting treatment and intervention to diseases or
the promotion of health, we force a host of conditions to be
labelled as health or disease. The controversy surrounding
the conditions of addiction seems to be a good example.
Alcohol and drug addictions cause much pain and human suf­fering. Society, for the most part has been at a loss for a
solution to deal with this problem. A movement to recognize
these behaviors as disease, has assured individuals that
treatment will be provided. Once a condition is granted
"disease status" several things change. The client is less
likely to be seen as morally weak or responsible for the
behavior, health professionals can legitimately intervene,
and reimbursement for treatment is more likely to be forth­coming from insurance companies. But using this criterion
as defining of disease opens the door for abuse and the
justification of treatment for disguised social reasons. The normative model endorses the conditional, if we desire to alter or treat a condition identified as dysfunctional, then that condition is a disease.

Moreover, as Engelhardt points out, the relationship holds in reverse; that is, if some condition is a disease, then treatment must follow. This clearly is not the case. Consider the following account given by Oliver Sacks in his book, *The Man Who Mistook his Wife for a Hat*, (1985).

A bright woman of ninety, Natasha K., recently came to our clinic. Soon after her eighty-eighth birthday, she said, she noticed a change: what sort of change we queried.

'Delightful!' she exclaimed. 'I thoroughly enjoyed it. I felt more energetic, more alive—I felt young once again. I took an interest in the young men. I started to feel, you might say 'frisky--yes, frisky.'

'This was a problem?'

'No, not at first. I felt well, extremely well—why should I think anything was the matter?'

'And then?'

'My friends stated to worry. First they said, "You look radiant—a new lease on life!"', but then they started to think it was not quite-appropriate. "you were always so shy," they said, "and now you're a flirt. You giggle, you tell jokes—at your age, is that right?"

'And how did you feel?'

'I was taken aback. I'd been carried along, and it didn't occur to me to question what was happening. But then I did. I said to myself": "You're 89, Natasha, this has been going on for a year. You were always so temperate in feeling—and now this extravagance! You are an old woman, nearing the end. What could justify such a sudden euphoria?" And as soon as I thought of euphoria, things took on a new complexion. . ."You're feeling too well, you have to be ill! (p. 97)
Mrs. K. was correct, she had neurosyphilis. But diagnosing the conditions was not the difficult task. Instead, the difficult question was whether to treat her for this condition. Again, let me quote:

Now the question of treatment arose. . .'I don't know that I want it treated' she said. 'I know that it's an illness, but it's made me feel well. I've enjoyed it, I still enjoy it, I won't deny it. It's made me feel livelier, friskier, than I have in twenty years. It's been fun. But I know when a good thing goes too far, and stops being good. I've had thoughts. . .I don't want it to get worse, that would be awful, but I don't want it cured, that would be just as bad (p. 98).

This example is a counterexample to the entailment relationship claimed by the normative model. If Engelhardt and Hare were right about the relationship between disease and treatment the prescriptive question could not be asked. However, this question is not only possible but at least as important, if not more important, than the question of whether it is a disease. These questions should be separate—what counts as a state of health or disease, and what conditions medicine and nursing should be lending their skills to alter are entirely separate questions. "Treatment" of political dissidents, masturbation, homosexuality, and antisocial behaviors should not be legitimated by broadening the definitions of health and disease. Society may decide such interventions are desirable, and health care professionals are the proper interveners, but the arguments to justify such
intervention should not rely upon a broadened and confused definition of health and disease.

Thus, the normative model is not an answer to the ontological question, 'what is health and disease?', but an answer to the practical question, 'what is the domain of medicine and nursing?' and the prescriptive question, 'what ought we treat?'. Blurring these questions and treating the normative model as an answer to all three questions is incorrect for it sanctions treatment of conditions for individual and societal goals on the basis that the condition is a disease, e.g., political dissidents and masturbation. An adequate account of disease should at least be able to exclude from its domain such conditions. Moreover, by conceptualizing the problem in this way, we fail to ask the prescriptive and practical questions separately, thus failing to require distinct justifications for interference (i.e., treatment) in individual's lives by the health professionals. What is needed is an alternative explanation for health and disease that does not depend primarily upon how we feel about a particular condition nor embed within the concepts of health and disease a justification for treatment.
An Explanation and Evaluation of the Naturalistic Model's Answer

Introduction

The naturalistic model answers the questions, 'what is health and disease?' by claiming that disease and health are value-free theoretical notions, and thus a matter to be decided by empirical science. This approach argues against the position that disease and health are socially determined constructs developed to explain certain undesirable or desirable behaviors or conditions. Boorse (1975, 1976, 1977, 1987); Fabrega (1981); Kass (1975) and Szasz (1978) all hold some version of this view. Boorse has been the forerunner in developing this theoretical model. According to the model, the explanatory or descriptive uses of the terms 'health' and 'disease' are the only legitimate ones.

Although appearing to be, in fact there is no inconsistency between Boorse and Engelhardt, or between the normative and naturalistic model. It has been wrongly assumed that these two explanations are given to address the same problem. Boorse and others within this tradition seem to be addressing only the question of what is disease and health, or more precisely in examining these terms as medical concepts, but not as defining of medicine. Boorse wants a general explanation of utterances of the type, 'Mrs. Smith has leukemia.' He assumes that the utterance, 'The cat has leukemia.'
leukemia,' can be given a similar account. Notice from the outset Boorse and Engelhardt have embarked on different questions, so it should be no surprise that they offer different answers. Boorse's account is independent of treatment and the domain of medicine and thus it is possible to have diseases which are valuable. I will argue that Boorse's account is at least superior as an answer to the ontological question, 'what is health and disease?', for it separates conceptually the problem of identifying conditions from the problem of treating conditions. I essentially accept Boorse's position, with a few revisions. I reject Boorse's claim that "software or programming disorders" are diseases. I show that Boorse has confused the cause with the effect in his analysis of certain "mental diseases" and that this error has lead him to incorrectly draw conclusions about some mental states. Second, the naturalistic model depends on being able to identify a species design. Part of what is entailed is being able to give a justification for partitioning the reference class. I make explicit the criteria that the naturalistic model (as discussed by Boorse) must endorse. Finally, I demonstrate that health can not be captured as this model defines it--as absence of disease. I argue for an entirely new approach to health that makes a case for health as more and less than this analysis
recognizes.

An Account of Diseases of the Body

Disease, on the naturalistic model, is generally seen as an internal state that is characterized by altered and damaged functional abilities. Health is seen merely as absence of disease. Boorse argues that the crucial distinction in the health and disease controversy is the distinction between what is normal and what is pathological. A bodily state or process is diseased, a disorder, or an injury only if it is pathological. Health is normal function and pathology is abnormal function. His notion of a function is strictly a biological notion and normality is a straightforward statistical concept. He claims that a condition is pathological when a part of the body is functioning below some standard efficiency for that specific part.

A condition of a part or process in an organism is pathological when the ability of the part or process to perform one or more of its species-typical biological functions falls below some central range of the statistical distribution for that ability in corresponding parts or processes in an appropriate reference class of the species (Boorse, 1987, p. 370).

Boorse claims that one can determine pathology when the specific reference class statistical distribution of a biological part-functional efficiency is known.
Kass (1975), in "Regarding the End of Medicine and the Pursuit of Health," comes to a similar conclusion.

Health is a natural standard or norm—not a moral norm, not a value as opposed to a fact, or an obligation, but a state of being that reveals itself in activity as a standard of bodily excellence or fitness, relative to each species and to some extent to individuals, recognizable if not definable and to some extent attainable (p. 26).

Thus on this account health is described as the proper working of each of the functions, relative to a particular species and discoverable by comparison against a natural standard or species design.

The reference class is not the entire species, but must be relative to the age and sex of the bearer. For example, incontinence is normal in infants, but abnormal in adults. Parts which operate at a level below the central range of functional efficiency will be pathological. Boorse considers functions as biological notions which contribute to a goal directed activity (9). For biology, the goal directed activity is generally agreed to be either the species' or individual's survival and reproduction. Boorse argues that the goal of biological functions, at least those of interest to the physiologist, is individual survival and reproduction. Cells are goal-directed to manufacture some compound; kidneys are goal-directed to remove waste; the heart is directed to pumping blood (10). Each of these functions
contributes to the overall goal of the individual's survival. The choice of the goal or function of the individual part is determined by the overall goal identified. This explains why the goal of the heart is not to make sounds, but to pump blood. It is the pumping action of the heart that is important to survival, not the presence or absence of sounds. The physiological function must have a causal connection to the survival or reproductive capabilities of the individual. In this analysis, functions are what are assessed as either normal or abnormal and functions are identified as processes that contribute to the individual's survival and/or reproduction.

The obvious question raised by this analysis is how far below the central range of efficiency must a function be to be pathological. It is difficult and probably impossible to draw the line precisely between normal and pathological conditions. As the efficiency of the part decreases there is some gray area in which it stops working well enough to perform its function. For Boorse, part of the decision of when this arbitrary line is crossed is context dependent. For example, consider the individual who has the sickle trait, that is, is heterozygotic for sickle-type hemoglobin. In malaria-infested environments this condition improves his chance of survival. However, if this same individual is placed high on top a mountain range where there are low
oxygen levels, he is at a disadvantage. The same condition which may in one environment improve his chance of survival, in another environment may decrease his chance. So it would seem that Boorse's account may evaluate the same condition as functioning well or functioning poorly depending upon the context. But in either instance the criterion for evaluation depends upon empirical conditions rather than a particular value, i.e., within the environment does the functioning of the part promote or inhibit individual survival. Thus the answer seems to be dependent upon the environment in which the organism must survive. This result leaves us in the position that being heterozygotic may be either pathology or health depending upon the context. This seems to be a strength of Boorse's approach— it permits adaptations within a subset of the population to be viewed relative to the outcome and does not require us to give the same description of each variation. Also it seems to give the flexibility needed with respect to other variations, like eye color and blood type. That is, these variations are not pathological since they do not diminish the ability of the part to perform its necessary function. The difficult question, "Is being heterozygotic simply a variation in species design that is desirable under certain environmental conditions or is it a disease which is desired under the right conditions?"
gets answered by what the consequence of the adaptation is on individual survival. This result seems to be a distinct advantage of this approach. Furthermore, this result illustrates that Boorse's disease/non-disease distinction is analogous to a similar distinction made in ethics, between moral relativism and circumstantial relativism. Just as the utilitarian may say that polygamy is right in one society and wrong in another (because of different circumstances) so Boorse says that some conditions may be disease in one environment and health in another. Neither Boorse's nor the circumstantial relativist's view entails that rightness (disease) is whatever people think is valuable (disvaluable). However, Engelhardt's approach, if viewed as answering the 'what is disease' question, is analogous to the moral relativist—what is disease (right) is what is disvalued (valued).

There has been much confusion about the choice of the goal for human functions. Boorse claims that the goal of biological functions is to preserve the individual or his close kin and it is because of this goal that functions are identified, e.g., heart directed towards pumping blood. Engelhardt argues (see p. 107) that Boorse claims that the goal of human functions is species survival. Engelhardt argues that if health and disease judgments depend upon what promotes species rather than individual survival many
conditions which cause harm or death to the individual would be tolerated and seen as health if they promoted species survival. W. Miller Brown has made a similar point.

Any efforts to clarify individual functioning and hence disease in terms of the proper functioning of the species also face the problem that long term individual survival after reproduction may not be evolutionary relevant. Indeed, the individuals of many species die shortly after, or even during reproductive activity (1986, p. 316).

But it should be clear from the discussion that Brown and Engelhardt are simply wrong on this point. Boorse argues that the goal of functions is individual survival and reproduction, not species survival.

Boorse's account is successful in making several distinctions that are required. It will class as a disease diabetes when the pancreas does not secrete enough insulin, but will not class as a disease the inability of a limb to regenerate after amputation. The appeal to typical functions does this work. Diabetes is a disease because it is a functioning below the species norm (11). Boorse's account will also classify as a disease both the increased and decreased functioning of the thyroid gland—even though on the increased side, it may be performing the typical function, it is not doing so with typical efficiency. In fact, this additional functioning eventually leads to other statistically abnormal functioning. It can also account for
the distinction between normal variation and underlying disease. The color of one's eyes, the type of blood an individual has, does not affect the functioning of these organs. Therefore these variations are allowable as normal.

**Psychological Disorders**

The above discussion handles the traditional physical diseases. However, Boorse gives a different analysis of psychopathology. He contends that psychological pathology can be given the same type of value-free analysis based upon species typical functional efficiency, but pathological conditions are not defined in terms of physiology. Rather another model of functions more appropriate to the psychological realm, psychoanalytical theory, should be used. Boorse believes psychoanalytical theory is the best model because it is the clearest theory involving well-defined mental part-functions. Furthermore he believes that physiological accounts of mental phenomena are not only inappropriate, but impossible to give because there cannot be a reduction of psychological concepts to neurophysiological explanations.

Boorse rejects the notion that mental diseases in the end must be brain diseases. He denies that mental or psychological disorders must be physically caused and explained
by physical laws. He argues that reasoning which claims a reduction of psychological states to physical states is fallacious because it assumes that the vocabularies of psychology and physiology are talking about the same object or process. He rejects the notion that mental processes are reducible to neurophysiology. Using his analogy of comparing the mind with a computer, he believes that psychological problems are not entirely hardware problems, but can also be programming or software errors.

Boorse holds that if we examine brains under a microscope they will never be able to tell us everything about the functioning of the mind (i.e., they will not reveal a person's belief system, nor will they tell whether the person could do calculus). His fundamental unit of analyzing brain/mental processes must be found within a theory which posits mental functions. Mental functions must be identified and the central range of efficiency of that function determined in order for pathology to be determined. His point is that the dysfunction (and disease) is present because of alterations in the working of these psychological functions. Boorse's claim is that there can be mental dysfunction even when the physical structure is intact.

Boorse argues that psychological disorders are states which represent a dated condition of a specific person, rather than an instance of some universal condition. For
example, a person's depression represents a particular state of that person and according to Boorse not everyone who is depressed shares this same neurological state. Boorse argues that persons in similar states may show no distinctive neural similarity. Thus mental diseases, even though particular cases are physically determined, fail to be physical diseases.

There is no guarantee that a mentally defined disease-type will coincide with any physiologically defined disease-type. Suppose for example, that a type of mental disorder is marked by ambivalent feelings toward the patient's father. The brains of various patients who share this disorder may show no distinctive neural similarity. Thus mental diseases, in spite of being everywhere instantiated by neural states, may fail to be physical diseases by failing to be physiologically definable (Boorse, 1976, pp.66-67).

Boorse is claiming that we can talk of mental functions which are typical, but that such functions should not be given a physiological analysis because there is no guarantee that there is a connection between this function and a universal physiological account (he does not deny that there is a particular physiological account).

Boorse is rejecting the claim that mental events can be described or are reducible to neurophysiological explanations. Rather he believes that we can represent mental events with functional descriptions and that this functional explanation is basic. He does not deny that mental events
are physically caused, rather he claims that there is no shared neurophysiological state for persons in the same mental state. Thus a person's pain has a physical cause, but there could be numerous physical causes of the same mental state. Persons who are psychotic, or suffering with an affective disorder, have an impairment in psychological or mental functions. Such impairments are explainable in terms of psychological laws that correlate a psychological state with a functional state—that is psychofunctional laws.

Boorse seems to hold that mental diseases are not physical diseases for two distinct reasons. One, some mental diseases are programming errors of a physically intact brain. In these instances when we study the neurophysiology we find the hardware identical with the hardware of a "healthy" individual. Two, a mental disease cannot be correlated with one particular neurophysiological explanation. On Boorse's analysis depression is a pathological state (a disease) not because of the altered amount of neurotransmitters, but due to psychological criteria. This is because on the physical level there is no biochemical dysfunction, only a biochemical abnormality. He explicitly claims that depression is a disease because of an altered mental state—not because of the neurotransmitter alteration (12). However this seems to be confusing cause with effect.
This is analogous to saying that angina is a disease—when in fact it simply is a symptom of an underlying condition—narrowed coronary arteries. We recognize depression through a known symptomatology, but these symptoms are not the disease. Just as with typical physical diseases their symptoms are different from the disease or pathology. In the case of depression it may be the symptom of several different (physical) diseases, i.e., each disease shares a common physiological explanation, but this is no different than the traditional physical diseases. For example, someone who has a set of symptoms, e.g., shortness of breath, moist cough, fever, may have any one of a large number of (physical) diseases. There is nothing mysterious in the fact that brain diseases manifest themselves as altered consciousness, loss of memory, or affective disorders for these are the functions of the brain.

Boorse claims that psychological or mental disorders need both neurophysiological explanations and functional explanations. This is not to say that all functional explanations will some day be reducible to a neurophysiological state, but that there are different types of mental states some of which can be reduced to neurophysiological processes and others which are reducible to functional explanations. Some of the mental disorders are true organic
disorders, while others are alteration of mental functions. Whether these disorders are diseases will turn on one's analysis of this concept.

Boorse is probably right that there are some disorders which are caused by how the person was "programmed" and not an alteration in the physical components of the system. These problems are manifested as personality disorders, specifically conditions like antisocial behavior, passive, aggressive personality. However such "programming errors" are more susceptible to a subjective decision about what we like and dislike. If the physiological basis of comparison is removed, it becomes very difficult to set "efficiency standards", thus making it difficult to determine parts functioning below the norm. The norm must clearly take-on a subjective and value-laden character. Because of this, these programming errors should not be considered disease or pathology. It is only when one can set the efficiency standard in terms of physiological criteria that one can avoid the direct tie with values.

**Determination of the Reference Class**

Finally, two problems with the analysis of the reference class have been made in the literature. One is a pseudo-problem, the second real. The pseudo-problem has to
do with universal diseases, i.e., this analysis can not identify universal diseases. First, it should be clear that it is only a problem when the disease is truly universal, that is, when the condition is present in the entire reference class, since the criteria of efficiency depends upon how that part is working within the reference class. If some individuals do not have the disease then Boorse's account will work. For example, Boorse's account can recognize tooth decay since the efficiency curve would include some individuals who do not have this disease. The efficiency standard does not depend upon the numbers who have the disease, rather on how inefficient or efficient a process is. However, this criticism is germane to all accounts of disease. For example, human beings do not presently have the ability to ingest arsenic without harm to their bodies or to regenerate a limb if lost, yet these inabilities are not a disease on any account. This is because it is not within the ability of the human species to do these things.

Finally, a general comment about the determination of a suitable reference class. A key element in his definition is that the statistical typical efficiency of statistical typical functions are determined as compared with members of a reference class. The reference class according to Boorse is: "a natural class of organisms of uniform functional
design; specifically, an age group or a sex of a species" (1977, p.562). On this account what is uniform functional design differs as to the age or sex of the individual. This makes obvious sense when one thinks of things like reproductive functions, teething of infants, but divisions are not clear cut once the organism reaches adulthood. The important criteria are the parameters used to define a particular group as an appropriate reference class. This is crucial when determining what the typical functional capabilities of the particular class includes. Boorse suggests that by abstracting from a large sample a species design will emerge as a reference class. But this approach is inadequate since it is quite difficult to pick out the relevant criteria for standardization. Brown also recognizes this problem.

It cannot be enough to argue here, too, that we find "natural kinds" by statistical correlations of normalizing traits, since so much depends on choice of populations which in turn seems to be guided by interests other than those of the theoretical biologist. In practice, of course, the choice of such populations may not be so difficult. But it is theory, not practice, which Boorse seeks to analyze (Brown, 1985, p.315).

For example, are the physiological changes that have been documented and correlated with aging natural? Do they represent a disease? If the reference class includes only individuals over eighty, rather than all adults of a particular sex, a very different picture of what is typical will emerge. Recent studies by physiologists studying the aged
have found data to challenge the conceptual approach that labels the typical dysfunction of aging as natural. Some changes that have been described as natural are being found to be the result of atrophy caused by disuse.

Why is male/femaleness an appropriate attribute for partitioning the reference class and not those with some specific genetic difference, e.g., PKU? The distinction cannot be made based solely upon a "uniform functional design", since all those with PKU have such a design. Rather the criteria for the partitions within the species must take into account the biologists' interests. That is, not only must there be a uniform functional design within each subclass, but this subclass must not identify subgroups which differ significantly with respect to survival. This second criterion is important in not dividing the reference class into subgroups which are structurally different, but which have different outcomes with respect to survival. Boorse subtly achieves this end by his choice of words—'design'. Most read into this term the notion that the outcome of the design must be favorable to the individual, or at least not detrimental. If we partitioned the reference class using some genetic difference, e.g., Down's Syndrome, the consequence would be unfavorable to the individual. Thus, I think the criteria operating within this system to
partition the set must be the following:

1. Each subgroup has a uniform functional design; and

2. the partition does not identify a subgroup whose members' survival differs significantly from other subgroups.

Given this as the criteria for dividing the reference class I think only the following subgroups can be justified.

1. Division into male/female

2. Age division—perhaps best divided by functional capabilities or differences, i.e., infants, children, adults (begins at puberty), and post-menopausal woman.

In summary, the naturalistic model answers the ontological question, 'what is disease?' by giving a value-free analysis of disease based upon the notion of statistically typical part-functional efficiency. This analysis makes sense when considering the traditional physical problems since functions are ultimately explainable physiologically. That is, kidney function can be described by telling a story about physical states, e.g., for kidney diseases one can talk in terms of sodium and potassium transport in the loop of Henle. Mental disorders are explainable in terms of functions from psychoanalytical theory. The functions are discoverable by scientific method and can be read off the species design.
The naturalistic model is an attempt to give a completely value-free analysis of health and disease that is applicable not only to medicine but for all biology. In this respect the two models, the normative and the naturalistic models are addressing two separate questions and thus we should not be surprised that they give different accounts. I have argued in this section that there are problems within the naturalistic model. When talking about the difficult question of psychological diseases, Boorse has confused in some places symptoms with the disease, or more generally the effect with the cause. Moreover, he is too quick to include as pathological, conditions which have no common physiological base. In fact he believes some of these conditions cannot be given a physiological description. I argue, that because of the likelihood of subjective reasons labelling "software" problems as disease, we should not recognize conditions as disease without the physiological basis of defining the "standard" efficiency. Also, I argued that giving a characterization of the reference class is more difficult than simply sampling to determine the species design. The choice of the reference class is influenced by the interest of the biologist—what is the reason the reference class is being choosen? Boorse's analysis must recognize the influence of these interests and include this within the statement of criteria for
partitioning the species into subclasses. With these two modifications to the naturalistic model we are successful in arriving at an adequate answer to the ontological question—what is disease? It is successful in including known diseases, e.g., pneumonia, leukemia, as diseases, and will exclude behaviors like masturbation and political dissidents. Moreover, this model does not confuse the prescriptive and practical questions with the ontological question. Additional arguments are needed with this model to justify treatment and to legitimate intervention by nursing and medicine. However, a separate discussion of the adequacy of this model for conceptualizing health is needed.

An Account of Health

We often talk as though health and disease are contradictory concepts that describe incompatible states-of-affairs. That is, if one is diseased, then he is not healthy, and if one is healthy, then he is not diseased. With some reflection though, it can be shown that this conceptualization is not adequate. The naturalistic model, as explicated by Boorse, and the normative model discussed by Engelhardt, endorses these concepts as contradictions. Health is defined as absence of disease. If disease is given this interpretation then few, if any, persons are healthy for we all have some part or process that operates below the typical
efficiency for that part or process. For example, someone with dental caries turns out on this interpretation to be unhealthy.

An alternative analysis of health has been developed that focuses on an ability to meet one's goals. For example, Caroline Whitbeck (1981) argues that health is a natural good and a clear asset for a human being. Health, on her analysis, is "the psychophysiological capacity to respond appropriately to a wide variety of situations" (1981, p. 613). By appropriately she means, "in a way supportive of, or at least minimally destructive to the agent's goals, projects, aspirations, and so forth" (1981, p.611). But this seems to class as unhealthy an individual with average intelligence if she desires to be a great physicist, for her inability to reach her goal is a psychophysiological problem. She lacks the intelligence to achieve her end. Most would be unwilling to claim that this is an unhealthy condition. Ingmar Pürn (1984) argues that "health is the state of a person which obtains exactly when his repertoire is adequate relative to his profile of goals" (p.5). Criticisms, similar to those made of Whitbeck's position, apply to Pürn's account also.

Both the absence of disease analysis and health as the ability to reach one's goals are inadequate to capture our pretheoretical notions of health. The absence of disease
account is too narrow for it includes most if not all persons from being healthy and the analysis suggested by Pörn and Whitbeck is too broad for it includes individuals who may have a serious disease as healthy. While it is true that anyone disease free would be healthy, not all healthy individuals are disease free. The key is being able to explicate this notion of health that includes some diseases but not others. I suggest a third analysis. The intent here is only to arrive at a working definition of health that improves on those presently available in the literature and that can be used in the discussions in Chapter Five.

Intuitively, we would call someone who is apparently disease free (unable to detect with present technology any disease, no subjective symptoms), except for a mild case of eczema as healthy, though we would not call an individual with coronary artery disease (CAD) as healthy. Both conditions fit our account of disease, but only one seems to make the person unhealthy. This is because CAD interferes with the organism's ability to function relative to his reference class while eczema does not. Health is the physiological ability of an organism to respond to its environment in a species-typical manner that permits it to survive and meet its basic needs. Health can occur in degrees—the
individual with no disease would be in "perfect" health, while the eczema sufferer is healthier than the person with CAD. The reason for this has to do with the kinds of properties health and disease generally are thought to be. That is, health and disease are different kinds of properties and for that reason should not be seen as contradictions (13). Health, described as the physiological ability of an organism to respond to its environment in a manner that allows it to survive and meet its basic needs is a dispositional property. This is especially clear when we use it as an adjective. A healthy individual is one whose physiology is relatively immune to disease. Even if an individual has a particular occurrence of disease, e.g., eczema, he may still have the ability to respond to his environment. Thus a person can be diseased and healthy at the same time. Boorse's use of 'absence of disease' is not synonymous with the usual usage of 'health' for it fails to have this dispositional reading.

On my account health is relative to what the individuals within the reference class can do and not on what the aspirations or goals of the individual are. On this account of health one can be diseased, yet healthy, if the disease does not compromise one's physiological abilities to maintain one's functioning. Furthermore on this account health is not an all-or-nothing property, but occurs in degrees.
Summary

There are numerous services offered by our present health care system. Many are services that meet people's desires, rather than treat or prevent disease, or promote health. My claim in the next chapter is that considerations of justice do apply to services that treat disease and/or promote health because a certain level of health and absence of disease is part of a satisfactory welfare level. Other services may be required by other moral arguments but the justification for these services is different than the one I give for health care services. This position requires a distinction between services that do treat disease and promote health, and those that do not. To enable me to make this distinction I have had to address the difficult question of, 'what is health and disease?'. This chapter has examined how the naturalistic and normative models answer this question. The normative answer was found inadequate to the ontological question for this model seems to be confusing several questions, i.e., what is the domain of medicine, what is disease and health, and what ought we treat. The naturalistic model of disease, with minor revisions, is an adequate answer to this question for it picks out those conditions which are clear cases of disease and does not include cases which are not diseases (e.g., masturbation).
However, the naturalistic analysis of health as absence of disease is inadequate for it fails to recognize the dispositional nature of health. With an analysis of health and disease that can be used to identify the set of services that are health care services we must now turn to the central question of this discussion, 'What health care services are required by a just society and to whom should services be guaranteed?'
CHAPTER V
A JUST DISTRIBUTION OF HEALTH CARE

Introduction

In this chapter I address the question of what health care services should be provided by a fair or just society and to whom. In Chapter Two I reviewed and criticized many recent attempts to answer this question and argued that a theory of distribution is required before we can consider an answer to this question. Additionally, I argued that this question is made more difficult by the confusion of what is health and disease. In this chapter I consider the consequences of adopting the satisfactory welfare achievement principle (SWAP) as the principle for allocating health care services to individuals and as the principle to distribute resources among the basic institutions within the society. This chapter essentially delineates to whom and which health services are required by justice. I first discuss the domain of health care services required by the analysis of health and disease given in Chapter Four. My claim is that health care services are those services related in some fashion to health and/or disease, and it is to
this set that SWAP is applied. A service delivered by a health care professional that does not treat or prevent disease, or maintain or promote health is a service excluded from the scope of this discussion. I am interested in determining what health care services (narrowly defined) are required by justice and who should be guaranteed these services. There may be other services offered by health care workers that some may claim must be provided because of other moral arguments. I do not deny this. However, these services require different justifications from the one offered here for services that treat disease and/or promote, maintain health. I consider the distribution of services required by SWAP both within the health care system and between basic systems or institutions within the society, e.g., education, health care, job development.

When we speak of a society being obligated to do something it is often unclear who holds the obligation. When I say that a certain distributional pattern is required of a just society I mean that the individuals within that society must develop a framework that brings about that end (14). Generally this is accomplished via the governmental bodies and structures, but there is no necessary condition that it has to be the government. I will speak loosely throughout of the government having the responsibility to develop structures so that SWAP is met, but it should be
clear other groups within a society may do so as well. It is assumed here that justice is a characteristic of a society that most find desirable. I do not argue why we should want a just society, or why that is a good, rather I assume this as a starting point and adopt a principle that I have argued in Chapter Three accomplishes that goal (15).

Moreover, it is unclear who will benefit from these obligations, i.e., who will be offered or receive these health care services. The answer to this question is intimately tied to SWAP and is considered in depth in a later section. Briefly, though, those individuals who need health care services to place them in a position to achieve a satisfactory welfare level must be guaranteed access to these services in most circumstances.

**Identification of Health Care Services**

The analysis of health offered and defended in Chapter Four is the following. Health is the physiological capability of the organism to respond to its environment in a species-typical manner that allows it to survive and meet its basic needs. Health can be of varying degrees. That is, there is no one state of health, but a variety of different states which individuals may be in. Many things may interfere with the physiological ability to respond. Services which maintain, restore or promote this state are
candidates for distribution. This, however, excludes several services that are offered for other reasons, e.g., comfort, wish fulfillment, increased happiness. The types of services that this distinction eliminates are many elective services, birth control and abortions in most instances, and cosmetic surgeries. By limiting health to the physiological response needed to maintain functioning, I eliminate the equivalency of health with happiness that is common with analyses of health which differ from the 'absence of disease' account. Moreover, I also avoid the problems with accounts of health that tie health with the ability of one to reach his goal (e.g., Whitbeck's and Pörn's account discussed in Chapter Four). Thus, this definition is broader than absence of disease, but narrower than other definitions that equate health with happiness or with the ability to reach one's goals.

Disease, on my analysis, is the inability of a part or process to perform one or more of its species-typical biological functions. This inability occurs when the functioning of the part or process falls below some central range of the statistical distribution for that ability in corresponding parts or processes in the appropriate reference class of the species. I argued that this definition covers not only human disease but applies to all species.
Moreover, this definition applies to both physical and psychological disorders. Any service that treats, cures, or prevents disease is included within the domain of services that may be required for distribution in a just society.

Hence, disease and health identification are tied to the physiological processes of the species and proper functioning is tied to the maintainence and survival of the individual. Using this analysis of health and disease eliminates a host of services generally believed to be health care services. For example, most abortions and birth-control counselling, and treatment for political dissidents are eliminated on this account. These services may be offered by physicians and they may be required by consideration of justice, but not because they are important for one's health or freedom from disease. They are not, strictly speaking, health care services. Society may decide that violent criminals need to be "treated" or that the growth of populations must be reduced and that physicians are the appropriate interveners, but the reasons why this intervention is legitimate has nothing to do with health and/or disease. I am not concerned here to address all services that the health care professionals may offer, only those offered to restore or maintain health, or to treat and/or care for diseases. What health care services must be provided or guaranteed by a just society begins with this
Resource Allocation within the Health Care System: What is Required by Justice

It is only in light of a theory of justice that a just distribution of health care can be discussed. In Chapter Three I argued for a principle of justice that is influenced by Rawls, Dworkin, Nozick, and Gauthier. The satisfactory welfare achievement principle that guides distribution is:

Justice requires a division of social goods that results in each individual receiving enough goods and services to allow achievement of a satisfactory welfare level, consistent with the most extensive liberty to choose and pursue one's life plan compatible with a similar freedom for all.

The just distribution of health care crucially depends upon this principle. I will explore in detail what is required by this principle and anticipate criticisms of this approach. This principle applies to health care since one of the basic requirements for being able to achieve a satisfactory welfare level is some degree of health and the absence of pain and debilitation associated with many diseases. Health care services should be distributed in keeping with SWAP so that everyone can achieve a satisfactory welfare level.

There is an important distinction that should not be overlooked in this discussion. What is required by the principle is the distribution of a set of services that
gives the individual the opportunity to achieve some level of health, not a guarantee of health. This is an important distinction for two reasons. One, it points out that the attainment of health is not a passive process; health can not be given to the individual. Second, the justice of the distribution is determined by the pattern of services, not upon whether one is healthy or ill. I will show that even though a person may be quite ill there may be no requirement by justice that the individual receive treatment.

Primary care services

Primary care services are services that maintain or promote health, or prevent disease. Prenatal care, well-baby care, cholesterol testing and diet counselling all fall within this classification. Primary care services are ones that generally require action on the part of the individual, e.g., a modification or maintenance of a diet, or compliance with a medication regimen. SWAP requires that services be available so that an individual can achieve a satisfactory welfare level. And since health and/or absence of (at least some) disease is included as part of the satisfactory welfare level and primary care services are specifically directed at health maintenance and promotion, or disease prevention, SWAP requires a broad distribution of these services. That is, because of the nature of these primary care services, SWAP requires that everyone have access to
these services and the resources needed to comply with any recommendation, e.g., diet, drugs, exercise equipment.

Herein lies a difficult question. To what extent must a just society go to fulfill this obligation? If one has special diet needs, is the society required to meet them? If the person is unable to meet these needs, then the answer is yes, for SWAP requires that one receive the goods and services needed to achieve a satisfactory welfare level. However, SWAP does not require the satisfaction of one's preferences or desires. If a person prefers to swim to get his daily exercise, instead of walking or running, the society is not obligated to provide him with a pool. However, it is obligated to provide a safe place to walk/run and the basic equipment necessary for this activity if he cannot do so himself.

One further issue must be raised—since on the analysis given in Chapter Four, there are degrees of health which level of health is required by SWAP? Does SWAP require the resources such that each individual can achieve a perfect level of health or something less than this? SWAP requires a level of health and freedom from disease that allows the individual to pursue life plans appropriate within that society. But clearly perfect health is not needed—not only is it impossible to achieve it is conceptually not required.
Suppose a well-known athlete, e.g., Carl Lewis, who is recognized as being in excellent health, develops a mild case of eczema on his arm. This disease does not interfere with his ability to compete or in any other way. Does SWAP require treatment? The answer is clearly no—this disorder in no way impedes Mr. Lewis' ability to achieve a satisfactory welfare level, thus no treatment is required. Also, because a satisfactory welfare level is relative to the development of the society, the services required to be available will differ from society to society. For example, the requirements will differ between third world countries and first world countries. Third world countries' obligations would include things like uncontaminated water, food, prenatal care; services that protect the individual from his environment. First world countries' obligations include these, but also technically sophisticated services that will improve one's health, e.g., kidney transplants. SWAP does not require services so that the individual can achieve the highest level of fitness, only that level that permits him to pursue other life plans to a satisfactory level. And this level is relative to the resources available to the society.

Secondary and tertiary services

By secondary services I mean routine, uncomplicated disease treatments, like appendectomies, cholystectomies,
and management of chronic diseases, like hypertension and diabetes. Secondary services are different from primary care services, in that secondary services attempt to cure disease or treat disease so that the individual can live with minimal interference in his life.

Tertiary services are sophisticated services offered by specialists and the delivery of these services is generally complicated by either the technical skill required to administer the treatment and care for the individual, or the individual has numerous other health conditions. The distinction between secondary and tertiary services is often done by the kind of institution offering this service. Community hospitals generally offer a wide range of secondary services, but not tertiary care services. Tertiary services are almost always limited to the teaching hospitals, that is ones with a strong affiliation with a medical school. Tertiary services are things like organ transplants, and experimental treatments that are linked to research projects. Since both secondary and tertiary services, as I have defined them, deal solely with disease treatment and restoration of health, it would seem plausible that SWAP may require any and all treatment available. However this is not the case.

To see why this is not the case I must go back to the discussion in Chapter Three. SWAP requires that the
individual receive enough goods and services to allow him to achieve a satisfactory welfare level, consistent with the most extensive liberty to choose and pursue one's plan, compatible with a similar freedom for all. Part of what this principle allows for is the freedom to choose how to live one's life. This means that one may choose to ignore all the health promotion and maintenance guidelines, and live in a manner that is known to cause disease and a loss of health. Not to permit one to make these choices would be an infringement on their liberty. For example, outlawing smoking would be one way to improve the health of almost all citizens (smokers and non-smokers alike, given the recent data on passive smoking), but such paternalistic interventions are serious violations of the individual's right to choose and pursue his own life goals. Certainly, given the strong equal liberties clause in SWAP, such interventions would be prohibited.

However, with such choice comes the responsibility to accept the cost of the choice. One such cost is the increased risk of disease associated with this behavior. If one is unwilling to accept the cost of such a gamble, that is if he loses and expects others to bail him out, then there is an imposition on other individuals who have fully accepted the risks and costs of their gambles. In this
instance the failure to accept the consequences of the risk-taking behavior free loads on the remainder of the population. If one chooses to engage in activities that carry with them a certain risk of health loss, and one knows or should have known of the risk, and the individual has had full access to primary care services then justice requires no further services. SWAP requires only that one have access to the services and resources to achieve a satisfactory welfare level. Thus, whether justice requires a distribution of secondary and tertiary care services depends more on why the individual is diseased. Dworkin's distinction of brute and option luck is helpful in making this difference clear. Option luck is luck associated with deliberate and calculated gambles; a gamble that one might have declined. Brute luck is a matter of how risks fall out, and is not in any sense a deliberate gamble. If one becomes diseased because of a gamble that could have been declined, and one was fully aware of the consequences of taking the risk, then if one loses, nothing further is required by justice. However if becoming ill is a matter of brute luck, justice requires additional services. This distinction is helpful but the claim that an individual is responsible for his illness is difficult to establish. Additionally those who are suffering because of bad brute luck, would seem to be entitled to an endless amount of resources. These two
issues need to be discussed in more detail.

Personal responsibility for one's health

The difficult thing then is to establish individual responsibility for one's choices. Daniels (1985) in his *Just Health Care* discusses a special instance of this problem—when can a worker be held accountable for the consequences stemming from the acceptance of a hazardous job. This is an instance of the general problem of determining when an individual can be said to be responsible for his choice and the costs associated with this choice. Daniels argues that what is required is that the individual be informed of the risks and competent to make a decision, and that the decision be truly voluntary. Daniels argues at length about the need to establish that the action/choice is voluntary. For example, if one is offered the choice of a hazardous job or unemployment most agree that the choice is not a truly voluntary one, that in some sense it is unduly constrained. Furthermore, there is a worry that smoking or other negative lifestyle habits are not truly voluntary. Media campaigns that seem to promise teens popularity, acceptance and love if they smoke cause concern that the smoking choice is not really voluntary.

Gerald Dworkin in "Taking Risks, Assessing Responsibility" argues that before an individual can be held
responsible for his poor health status three things need to be established;

that the individual was in some way at fault in behavior; that the faulty behavior produced the lowered health status; that the faultiness of the behavior created the damage to health (1981, p.30).

Dworkin argues that the fault condition will not come into play in most instances because of particular conditions that function to excuse or justify the behavior, e.g., people do not take their hypertensive medications because of their adverse side effects. Dworkin's fault condition is analogous to Daniels' requirement that action be truly voluntary. Both are concerned that the individual's actions are not unduly constrained. Dworkin believes that it can be shown that the unhealthy "behavior does not originate in the defective character of the individual but in circumstances external to that character" (p. 31). For example, people accept hazardous jobs because their market skills are limited; people smoke because they are manipulated by advertising and peer pressure, and people drink in excess because of a genetic predisposition. However, in those instances where fault can be established, Dworkin believes that basic considerations of justice will show that it is not unfair to treat these individuals more harshly than others. The role of choice is essential in showing this.
What is needed to show personal responsibility for one's health or to show that one is at fault in behavior is to establish that one's health choices and behaviors are voluntary. A voluntary action is an action taken under the following conditions:

i) it is reasonable to expect that the actor knows or should know the risks associated with this action, e.g., most everyone smoking today would meet this condition;

ii) it is reasonable to believe that the individual has the ability to choose not to engage in the behavior; and

iii) it is reasonable to assume that the individual has an acceptable set of known alternatives open to him (16).

For example, take the unemployed individual who must choose between working in the coal mine (and subjecting himself to all the dangers inherent in this work) or being unable to feed his family. His decision to work in the coal mine is plausibly not a voluntary action for the options open to him are unduly constrained. Likewise, an individual whose diet is mostly fried red meat, who has few resources to make changes in this diet, is constrained in a relevant way. If one has a broad range of alternatives, is knowledgeable about the risks associated with each choice, and has the ability to choose an alternative behavior, e.g., several job choices that would adequately support one's self
and family and one knew of the risk associated with each, then the choice would be voluntary on my account. Furthermore, if the individual is in a fair society and has access to primary health services that educate and assist individuals in the development of healthy lifestyles, then choices under these circumstances would be voluntary also. One can be held responsible for his decisions under these conditions.

Part of accepting the risk may include paying additional costs for health and life insurance. In these instances the individual, recognizing the risk, has contracted to receive benefits if he loses his gamble. Under this circumstance the individual will be entitled to treatment, but for different reasons. Nothing in my approach prevents this from occurring. What I have claimed is that an individual who chooses voluntarily to smoke, eat red meats, or pursue other dangerous life-style habits can not expect, as a matter of justice (i.e., no special contracts for the provision of these services), to receive all the care or treatment needed for his lost gamble. The fulfillment of such expectations freeloads on those who are risk-averse and on those who accept the cost of their gambles, whether they win or lose.

However one may argue that almost everything we do includes some risk, even driving to work. If this is true then justice would require little in the way of health care
services. Since all of our actions include some risk I must show that there is a difference between the risks associated with daily living and those associated with smoking, or driving without a seatbelt. This difference is that a certain level of risk is inherent in daily living, but that some activities (e.g., smoking, not using a seat belt) assumes risk over this level. While it is true that we may be able to avoid any particular risk (e.g., not driving to work), we can never avoid all risk. It is the risks above this level that are key in assessing one's responsibility for action. But a consequence of this argument is that certain voluntarily assumed risks, e.g., health workers voluntarily taking care of AIDS patients, will place these individuals in the same class as the "Evil Knievel" types. This consequence can be avoided if we take into account the social value of the risk assumed. This is relevant since the society needs certain positions filled. Thus two factors must be considered; 1) is the risk in the category above those assumed to be associated with daily living; and 2) the social relevancy of this voluntarily assumed risk. If the risk is above the "acceptable" level and there is no relevant social reason for such assumption, then the individual must assume responsibility for and pay the costs associated with their risks.
But this answer assumes that risks are an all-or-nothing thing. That is, the development of disease or poor health is completely traceable to the risky behavior. However, this is not usually the case. A smoker's cancer may be unrelated to his smoking or the smoking may be only a partial contributor. Heart disease is an even clearer example of this. Data support that lifestyle habits, i.e., diet and exercise, influence the incidence of heart disease, but that also a genetic predisposition is important to its development. Here we had a case of bad brute luck (genetic predisposition), that is manifested when an individual makes bad lifestyle choices (no exercise, red meat eater). Is the person responsible for the development of the disease entirely, only partially, or not at all? Part of the difficulty with answering this question is our inability to identify the "real cause". Moreover, if the risk taken is small in comparison to other causal contributors how are we to account for this? For example, suppose I am driving on the interstate with my seat-belt fastened, but I drive over the speed limit by 5 mph. An accident occurs in front of me and I am unable to stop before hitting one of the cars in the accident. I am injured—am I responsible for my injuries? The additional speed does play some contributing role in my injuries but slight in comparison to other
factors.

These examples raise difficult questions about what is required by justice. Even if we can establish that certain behaviors are voluntary, to hold one accountable for a risky behavior and as a result to limit or deny treatment, we must be relatively certain that the voluntary behavior is the (or a) cause of the lowered health status. To address this issue completely would take us far afield from the original topic into a discussion of the nature of causation. But some more systematic treatment of these cases is needed. I delineate the class of cases that I think we must be concerned with and suggest a possible beginning solution in each case. These solutions vary as to their adequacy. However, the underlying principle is clear: If a behavior $x$ is voluntary and $x$ is known to play a relevant causal role in the alteration in health status, then justice requires treatment and assistance inversely proportional to the extent that $x$ is said to cause the disease or health alteration. That is, if the behavior is voluntary and known to cause the health alteration entirely, no treatment is required by justice.

There are five major classes of cases that must be discussed (with subclasses in some).

1) **Clear causal dependency:** It is clearly known that $x$ caused or brought about an alteration in one's health
status. An example is the individual, who on a clear, dry day takes to the road on his motorcycle without a helmet and drives at 120 m.p.h. into a telephone pole (that is properly placed at the required distance from the road). If this behavior is voluntary (and assume here that it is), then SWAP requires no assistance to this individual. For my purposes here, this is the ideal causal case. Of course, there are many variations that we could add that could complicate this immensely, but I will get to those in a moment. It seems clear that this individual has voluntarily chosen a particular action that was hazardous, and must bear the costs of such a choice. Any other decision free loads on those who are risk-averse and on those who accept the cost of their gambles, whether they win or lose.

ii) Interactionist causation: In these cases the disorder (or the disease) is caused by the interaction of many factors. Some of these factors may be necessary, but not sufficient for the disease. In these instances SWAP requires services to the extent the disorder is causally related to voluntary behaviors. If there are necessary conditions that are entirely voluntary behaviors, then SWAP would require no treatment. In other cases where this is not the case—the necessary condition(s) are not voluntary behaviors, then treatment is required. In other cases where
there are a host of causal factors that are sufficient for the disorder, treatment is required to the extent that these factors are voluntary in nature. Obviously there are serious epistemic issues. We must know with some probability the effect a behavior does have on health status. For example, we know the probabilities that certain behaviors have on decreasing or increasing one's risk for cardiovascular disease. To the extent that such probabilities are known they must be taken into account when considering what treatments are required by justice.

iii) Compounding factors: Some voluntary behaviors can compound or make worse a disease, but are not causal in the relevant way. That is, these compounding factors are not required for the occurrence of the disease; individuals acquire this disease independent of these factors and these individuals can not be said to have caused their disease in any way. For example, juvenile onset diabetes is thought to be caused by a virus that destroys pancreatic cells necessary for the production of insulin. Another example is essential hypertension for which the causal mechanism is unknown. Both diseases can be made much worse by noncompliance to treatment regimens. A juvenile onset diabetic who maintains poor control of his blood sugar because of dietary and exercise habits may accelerate the complications known to be associated with the disease. Hypertensives who fail to take
their medications and eat diets high in salt may accelerate the cardiovascular complications associated with their disease.

What is required in these cases? SWAP requires the resources to treat the primary disorders, but as complications arise from voluntary behaviors, treatment is not required. Again, the amount of treatment depends upon the extent the complications are known to be associated with the voluntary behavior.

iv) **Causal overdetermination:** Causal overdetermination occurs when there are two (or more) factors that together bring about some event, but that in the absence of either, the same result would occur. For example, an individual is shot simultaneously in the heart and head. In this instance death results from both, but either would have been sufficient. If there are diseases that would fall within this class (and I am not sure there are) what is required by SWAP? If both causes are voluntary then no treatment is required: this is simply an instance of (i). If neither is voluntary then treatment is required; this is an instance of (v). Thus only one sort of case is of interest here. That is when one of the behaviors is voluntary and the other is not. For example, a smoking coal miner would have developed emphyzema from either the smoking or the mine work and only
the smoking is voluntary in the relevant sense. Do we treat? This is a difficult question, but assuming we know all these facts, SWAP would be indifferent. I think an argument could be made either way. However, given that there is some reason to treat (the employment as a coal miner) then we ought to treat. Because of the nature of the decision, it seems a better state-of-affairs to treat rather than not in unclear or ambiguous situations.

v) No known causal dependency: This is the other end of the continuum—no behavior that the individual has engaged in meets both the voluntary condition and the causal condition. That is, he may have engaged in certain behaviors that are causally known to the scientific community or other groups as the cause or a cause to some disease (e.g., asbestos workers), but can not be held accountable for this behavior since the voluntary condition is not met. In this instance SWAP would require treatment.

A great deal more analysis is needed on these cases, especially (ii) through (iv), to specify exactly what is required by justice. Some of this work is the scientist's—to explain antecedent factors that may influence the probability that if one engages in a behavior then he/she will become diseased. But there is a substantial amount of philosophical work that must be done refining the classifications and determining what justice requires within each category.
Further limitations on what is required by justice

In addition to the limits discussed in the above section two further restrictions on services must be considered. If a person loses his health or becomes diseased through bad brute luck, SWAP seems to require us to continue services until some level of health is restored or death occurs. However this is at least wasteful, and perhaps wrong. When it becomes clear that there will be little benefit achieved by further allocation of resources then no further resources are required by justice. This dilemma is no different from the distribution of other social goods. For example, at some point the decision must be made that an individual has received his educational opportunity, even though the desired outcome has not been achieved. SWAP will not typically require us to continue to pour resources into a losing cause. At some point (clearly somewhat vague) it can be recognized continual support and allocation of resources will not be successful in providing the capacity for achieving a satisfactory welfare level. But SWAP does not require us to stop assisting for this reason. If resources were infinite, it surely would require continual support. However, in a society of moderately scarce resources, allocating resources to cases when there is good evidence that they can not help, is denying services
to others in need. When this decision effects the distribution of health care it is a particularly difficult decision since the individual is seen as blameless, and the decision one that will almost surely result in the individual's death (17). To decide that further treatment will not help can be a difficult decision. However it is important that this decision is made in the appropriate cases.

Another sort of case must be considered. Suppose two treatments are available for a condition that is equally effective, but one requires some minor lifestyle change (e.g., modified diet) and the other requires no change. Furthermore the first treatment is relatively inexpensive while the second is very costly. Does SWAP require that we have access to the expensive service? The answer seems to be clearly no, for reasons analogous to those discussed in the previous paragraph. SWAP requires that one have the ability to achieve a satisfactory welfare level—the first treatment meets this requirement—and not a satisfaction of one's preferences. Additionally in an environment of moderately scarce resources, expending resources in the second case is denying some other service to others.

Let me summarize what has been established so far. The satisfactory welfare achievement principle requires that individuals be given enough resources and services so that they can achieve a satisfactory welfare, consistent with the
most extensive liberty to choose and pursue their life plan compatible with a similar freedom for all. Part of what is included within a satisfactory welfare level is a level of health and freedom from disease so that the individual can pursue his life plans, but not a requirement to attain perfect health. Services that treat, cure, or prevent disease and/or maintain, restore, promote health are the proper services to be delivered by a health care system. Services provided by health care professionals that do not treat disease or promote health are excluded from this set. What services are members of this set ultimately are determined by what is health and disease. On my account health is the physiological capability of the organism to respond to its environment in a species-typical way that allows it to survive and meet its basic needs. Disease is the inability of a part or process to perform one or more of its species-typical biological functions. Thus the boundaries for the set of health care services are determined based upon this analysis of health and disease. It is further limited by considerations of SWAP. SWAP requires that each individual have access to primary health care services, and resources needed to follow through with these recommendations. Moreover, SWAP requires that treatment of diseases and services to restore health be available to all when this
health loss and/or disease occurrence is not the result of an individual's gamble. In instances where the individual has been given the primary care services needed to maintain or restore their health, and the individual gambles (e.g., engages voluntarily in an activity with known health risks, and there are no special contracts) and loses, then justice requires no or only partial treatment. But even in instances where justice requires disease treatment this obligation is not without limits. When it becomes clear that additional resources will have little or no chance of working no further services are required by justice. And if several treatments are available, the costliness of these interventions is relevant.

One further note of explanation is needed. The claim of the above section is that everyone should have access to a set of services and that society should guarantee their availability. How is that accomplished? Who has the burden for payment? SWAP has no specific social requirement, that is SWAP does not favor or require one social structure over another. This goal can be achieved through a socialized program, where all receive the same set of services, paid for through some sort of community fund. Or a modified capitalistic system can accomplish the same goal, with an insurance strategy that has a mechanism (i.e., a tax) for those who have done well within the social structure to pay
the premiums for those who cannot afford them. As is required by SWAP those who have benefitted by living within a social structure, must return part of their gains. An infringement on provider's liberty

A serious issue remains—individuals must receive health care services from people. Even if all readily recognize that a just society has an obligation to provide such services there remains the concern that to fulfill this obligation the society must violate the liberty of health care providers, especially physicians by restricting their choice of where, what and on whom to practice. If this is true there would be an unacceptable infringement of an individual's liberty and SWAP could not require the distribution discussed. I will show in this section why this is not the case.

First, it should be clear from earlier comments that SWAP does not apply directly to physicians and other health care workers. The burden of fulfilling this social obligation does not fall solely upon them. SWAP is a requirement on the basic social institutions of society to be structured in such a way that the individuals within the society can achieve a satisfactory welfare level. Thus the requirement is on society, i.e., the government, to structure the health care delivery system to comply with
SWAP. But even given this clarification many physicians will claim that SWAP will permit the government to make decisions about who will be educated and who will be reimbursed. This consequence, they argue, is an infringement of their liberty. For example, suppose John Smith is deciding what area of medicine to choose. He decides that he would like to go into the field of neurology. However he is told that there are no residency openings in neurology and that he must choose another field (18). Now the libertarian physician sees this as an infringement. Consider a slight modification. There are residency programs available but John must agree to practice in a remote area in Montana as part of the conditions of acceptance. The libertarian physician will continue to see this as an infringement of his liberty. An outside agent is determining conditions of employment that the medical community would see as interference in their right of self-determination.

But this infringement is no more than most individuals face when they choose a field of study and look for work. Choices must be made as to what will be taught. For example, most would think it odd to claim that a reduction in government support of horse shoeing programs violates the liberty of the student. The assessment is made that there will be little need for blacksmiths in the future, so
support of these programs is not needed. Similar decisions must be made about what health care providers are needed and in what areas. The government must develop a system which assures access to health care services to all citizens, while not requiring exceptional sacrifice from providers. Providers must be given similar opportunities as other workers. However SWAP does not require the complete freedom to choose where, what, and on whom to practice. SWAP only requires liberty compatible with equal liberties for all. A health care delivery system structured to assure access by only reimbursing those who choose to practice within the system or by limiting training programs to those specialties needed in society is not infringing on the liberties of the provider unfairly.

There is one final criticism physicians will almost certainly make. Such allocation of health care services interjects a third-party into the physician-patient relationship and such interference undermines the special relationship between physician and patient. Daniels (1985) has suggested a response to this criticism. The physicians role in the health care system is to deliver a package of services, diagnostic and therapeutic, which carry various benefits, harms and risks. The physician is to act in the patient's best interest, by informing the patient of
treatments available, making the patient aware of which treatments plans maximize quality, and pursing a treatment plan if the patient agrees. The critical question, as pointed out by Daniels, is:

whether society is obligated to permit health care resources to be allocated purely in response to physician-patient intentions to maximize absolute care? (1985, p. 137)

The clear problem is that since resources are limited there will never be enough to meet demand. Consideration of justice will force us to question distributions made in response to "unrestrained pursuit of absolute quality" (Daniels, 1985, p. 137). Limitations will be placed on the allocation of resources (e.g., the present choice is not to offer primary care services to those on Medicaid) and the crucial decision is what principles shall we use to limit care. In a system of moderate scarcity constraints placed by considerations of justice at least provide that the allocation is fair and not arbitrary. Other contenders, like the status of the individual within society, seems to take into consideration a factor that at least prima facie is irrelevant. Using considerations of justice does not disrupt the physician-patient relationship—the physician remains in his primary role as the deliverer of a package of services, the package is simply constrained by considerations of justice.
Is this approach inhumane?

Many may argue that such a system, constrained by considerations of justice, is cruel and inhumane. It holds individuals responsible for their choices and does not provide guaranteed treatment for those who have gambled and lost. Though this may be true, two points need to be made. First, it must be kept in mind that a basic assumption of this dissertation is that we are operating within a society of moderately scarce resources. This means that limitations must be placed upon the allocation of health care resources. The key issue is how this is accomplished. If we consider the present health care delivery system and the method of allocating resources within the system, two principle mechanisms are evident. Those with the financial resources can buy any available service desired or needed; political power directly influences the researchers and practitioners who are funded and to what extent. Powerful lobbies ensure that physicians remain at the center of the health care team; that sophisticated and technical services are funded at the expense of access to basic services for the poor; and that the cornerstone of care for the elderly is institutionalized services rather than home based services. A second assumption has been that other moral considerations may dictate an additional allocation of resources, as long as this additional allocation does not result in an unfair
distribution. Withholding a basic service for a self-imposed injury when delivery of this service will not upset the distribution required by justice may be cruel or inhumane, but it is not unfair. SWAP gives us a principled way to distribute resources within society.

Resource Allocation between Social Institutions: What is Required by Justice

Up to this point the subject of this chapter has been the resource allocation within the health care system, i.e., what health care services will be guaranteed and to whom. But there is a different question that must be considered—the resource allocation between social institutions. By this I mean: how can we allocate resources between the social systems so that the individual has the goods and services necessary to achieve a satisfactory welfare level? Can SWAP help us make decisions about whether resources should be allocated for additional training services or for transplant services? If it cannot then there is a serious incompleteness in the theory.

Recall that SWAP requires a redistribution of resources so that every individual can achieve a satisfactory welfare level. Many things besides health care may be needed for one to achieve a satisfactory welfare level, including educational and job training services, counselling and testing to evaluate and determine one's
skills, food, clothing, and shelter. How we determine an allocation of resources depends partially upon the development of society, and partially upon value choices within the society. One clear consequence of SWAP is that funding for lost gambles is not required by justice. For example, treatment and research needed for diseases directly the result of lost gambles will not be funded (19).

Distribution is dependent upon the social development since this development determines in large measure what is available for distribution. The focus in third world countries will be on basic necessities, food, sanitation, clean drinking water, decent shelter, and adequate clothing. Education will focus on primary and secondary education, rather than college or graduate training. To raise distributional questions that are presently the subject of debate in the United States would be inappropriate. For example, to raise the possibility that the government of Ethiopia would fund research and development of artificial hearts is obviously ludicrous. To reduce funding for the basic necessities in order to research and fund a technology with limited use is in opposition to SWAP. One clear guideline that SWAP gives us is, if the resource allocation for something limits or negatively effects the resources available for individuals to achieve a satisfactory welfare level, then it is
However one may argue that not all decisions are this simple or clear. Suppose the funding decision is between two services needed for some individuals to achieve a satisfactory welfare level. For example, there are diseases (not the result of lost gambles) to which we have no treatment and some individuals within society are in need of special, intensive training to acquire job skills. Perhaps both areas need research funds to develop a response to the problem. How do we decide which to fund (assuming we can fund only one)? Certain factors can be used in our evaluation; the likelihood of success of the programs; the resources required to bring about this success; the condition of the individuals effected by either problem. SWAP is not helpful here and the final decision will be guided by value choices of that society. Judgments about the cost relative to the gain, the degree these services help and the desirability of developing new technologies will guide in these decision. However, being unable to supply all the services needed does not relieve society of the obligation to provide other essential resources. That is, suppose an individual is severely mentally handicapped, and no training exist that can assist this individual in performing a job or skill. Justice does not require that every disease be cured or that every individual become a professional, rather
it requires that the individual be given the resources and services that are required to achieve a satisfactory welfare level, given one's natural talents and abilities.

Therefore, SWAP requires that resources be distributed so that everyone can achieve a satisfactory welfare level. Many types of resources are needed for one to achieve this level. Part of the actual distributive decision depends upon the resources available and the needs of the individuals within the society. If allocating resources for the development of some technology, e.g., heart transplants or nuclear energy, is done at the expense of basic health services or decent housing, then SWAP has been violated. However, in instances where a satisfactory welfare level is reached and the society is in the position to develop a new technology, either heart transplants or nuclear energy, SWAP is not helpful. My claim is that these decisions are a function of the values held within that society, taking into account such things as the benefits and cost of the research and development, and the extent of the problem being researched. SWAP cannot guide in these instances.

Policy Recommendations

In this final section I will consider some of the consequences of adopting the satisfactory welfare achievement principle as the principled mechanism for
distributing health care resources within society. I assume that little needs to be said about the inequities of our present system and the fact that our present system lacks a principled way to make distributional decisions. Decisions about allocation are based all too often upon who is the most vocal or powerful within the system. Health care decisions do not favor those without power, but rather those with powerful lobbies and political influence. The recent decisions by the Ohio General Assembly to continue funding institutionalized care for the elderly, but reduce the funding for home based service is one example of this.

SWAP would require decisions to be made constrained by considerations of justice. This could be done in several ways. Keep in mind that this discussion assumes that individuals have the resources to achieve a satisfactory welfare level and that everyone either has, or has been given the opportunity, if able, to find meaningful work. Thus this discussion of using SWAP to develop health care policy is done assuming a society is governed by SWAP in all distributional question. Four clear policy guidelines emerge from SWAP relative to health care distribution.

1. All should have access to primary care services which treat disease and/or promote health.

2. All should have access to treatment for health care problems that are the result of brute luck. However these
services are not unlimited. When the allocation of services begins to infringe on the services of others, and the continual allocation has little chance of succeeding, justice does not require further treatment.

3. The research and development into treatments for disease that are clearly caused by risky health behaviors can not be funded by public monies. Any research and development done on these diseases must be financed through private donations.

4. Individuals engaging in risky behaviors should assume financial liability for treatment of these disorders (unless the assumption of this risk has a particularly significant social value). This could be accomplished by imposing increased insurance premiums on those who smoke, drink, engage in other risky activities. Or a tax could be placed on "unhealthy" products—e.g., cigarettes, alcohol. SWAP favors the former strategy. If one is willing to gamble, and accept the full cost (not expect health care services if disease occurs) of the loss, then the latter strategy, forcing all to pay the surtax, will not give him this freedom.

To illustrate how these guidelines could assist with actual policy decisions consider the decisions that would be made based upon SWAP and these guidelines with respect to
AIDS.

1. Given that AIDS is thought to be preventable a widespread educational effort would be required by justice to ensure that individuals are knowledgeable about the risk they are assuming and how the disease can be prevented.

2. Those individuals who have acquired the disease through brute luck, as a result of blood transfusions or the children of AIDS victims, need to have access to whatever help is available.

3. At this stage of our understanding of the disease, justice would still require research and development monies for the study of AIDS. This because the causal mechanism is still far from clear, and even though evidence points to certain behaviors as being crucial in the transmission of the disease, much is still unknown about the disease. Furthermore, given the serious nature of the disease it is crucial that more be known before we limit these monies.

4. According to SWAP, those who are determined to be responsible for their disease are not guaranteed care. The individuals developing the symptoms of AIDS at the present time would not meet the knowledge requirement—that is they engaged in the activity without knowledge of the risk. Those coming down with the disease are required by justice to receive care. But as the knowledge of the risks associated with certain behaviors becomes more common this will
change. Justice does not require guaranteed access when one can be said to have engaged in the risky activity voluntarily.

**Summary**

This chapter has examined the distribution of health care services required by the satisfactory welfare achievement principle. I argued that health care services are those services limited to treatment of disease and/or promotion of health. Other services offered by physicians and other health care professionals that fall outside the scope of this analysis are not addressed by this argument. SWAP requires that each individual have access to primary health care services, and resources needed to follow through with these recommendations. SWAP requires that treatment of disease and services to restore health be available to all when this health loss is not the result of an individual's gamble. In instances where the individual has been given the primary care services needed to maintain or restore their health, and the individual gambles (e.g., engages in an activity with known health risks, and when such engagement is truly voluntary) and loses, justice requires no or only partial treatment. But even in instances where justice requires disease treatment this obligation is not without limits. When it becomes clear that additional
resources will have little or no chance of working further services are not required by justice. And if numerous treatments are available the costliness of these treatments is relevant in determining to what one may be entitled.
CHAPTER VI

SUMMARY

The purpose of this dissertation has been to examine what health care services ought to be provided by a just society and to whom. This is a serious and relevant question at a time in which budget deficits and reduced funding will restrict services. A fundamental concern must be the reasoning and principles used to determine what restrictions are justified.

This dissertation has examined arguments on both sides of the health care distribution controversy. Arguments given by individuals who wish to justify a broad distribution of most services to all were reviewed. These arguments are essentially of two types— that health care services ought to be provided because it is the humane or decent thing to do or that individuals have a right to these services. Both of these arguments are inadequate for they fail to justify the redistribution required to bring about their end. The other side of this dispute, most vocally expressed by the libertarians, is that there is no justification for a redistribution because such actions interfere with the
liberty of individuals. Even accepting this theoretical framework, there is good reason to question the libertarians claim that government has no role in the redistribution of health care services. Several services fall into the self-defense category and are justified on this ground. Of course this argument can never establish what the liberals wish to establish, but it does demonstrate that the libertarians are wrong in their claim that government has no role in health care distribution. What becomes evident though, as a result of reviewing this controversy, is that what is at dispute is not how to distribute health care services, but all services within the society—that is, the theory of justice upon which these positions must rest.

I argued that a pure procedural conception of justice as formed by the libertarians is flawed because it fails to establish property rights to natural or common assets and fails to demonstrate that ownership of one's talents and abilities necessarily entails ownership of all gains generated by these talents. I argued for a satisfactory welfare achievement principle (SWAP) that claims that justice requires:

a division of social goods that results in each individual receiving enough goods and services to allow achievement of a satisfactory welfare level, consistent with the most extensive liberty to choose and pursue one's life plan compatible with a similar freedom for all.
This principle is preferable to other plausible contenders as an end result principle of justice because it accepts human beings as risk-takers and requires that they be held accountable for the costs of their risky choices. Furthermore, it does not require that each individual achieve a satisfactory welfare level, only that an individual have the resources and services available that would permit him to achieve that end. This principle is successful because it is able to take into account an individual's work effort, his moral luck, including the fairness or unfairness of one's starting point. Like most other end result principles it permits an unequal distribution of resources.

But the crucial question for this dissertation is what does this principle require with respect to the distribution of health care services. Unfortunately it is not as easy as simply determining what the principle requires with respect to these services. When one begins to think about the composition of the set of health care services, one finds all sorts of things normally believed to be in that set that are questionable. Services like cosmetic surgeries and abortions simply for birth control are services offered to meet people's desires or wishes rather than to treat disease or promote health. Limiting the set of services to those that treat disease and/or promote health is one way to limit this set. But in order to do that, a review of health and
disease was required. I argued that the value-laden interpretation of health and disease, or the normative model, is inadequate for it fails to answer the ontological question of 'what is health and disease?' I argued for a naturalistic model interpretation of disease, very similar to the one offered by Christopher Boorse. Disease on this account is functioning below the statistical typical efficiency for that part or process when compared to the appropriate reference class within the species. I argued that this analysis works for both the traditional physical and psychological diseases. However, health is more than absence of disease as Boorse contends. Health is the physiological ability of an organism to respond to its environment in a species-typical manner that allows it to survive and meet its basic needs. This analysis of health permits the dispositional reading that health usually has and allows us to make sense of the claim that an individual may be healthy even though he is diseased.

With a foundation established for what services are the subject of redistribution I argued that SWAP requires that everyone have access to the primary health care services available within that society. This because health (at least some level) is needed to achieve a satisfactory welfare level. Other services that treat disease should be
available to those whose disease is partially or entirely the result of brute luck. However, when continual services will unlikely be successful in improving one's chances of achieving a satisfactory welfare level, justice does not require further services. This because such a distribution, in an environment of moderate scarcity, will deny services to someone else who has a better chance of benefitting from these services. The services that are available in a society will be relative to the development of that society since what will count as a satisfactory welfare level is relative to this development. Thus I claim that justice will require that everyone have access to the primary care services available within that society, but that services may be limited because of an individual's behavior or because the service will not likely be helpful.
NOTES

(1) This argument is similar to the one given by Peter Singer (1983) in *Famine, Affluence, and Morality*.

(2) Even though Outka's argument has been presented in many texts I think it can be dismissed as a serious argument for equal distribution of health care. He claims that a right to health care really means that all individuals within a society ought to have equal access to health care delivery. His argument is that justice requires that we treat individuals differently only if in fact there is a relevant difference. With regard to health care distribution, the only relevant criterion is need. Any denial of available health care based on anything other than need is unjust. There are numerous problems with his argument, but the most serious one is that he never states why need is the only relevant criterion—why isn't the ability to pay for the services a relevant criteria. Absent this, Outka's approach is unacceptable.

(3) Daniels adopts Christopher Boorse's account of disease as the deviation from the natural functional organization of a typical member of a species. Because of this he also inherits the problems in Boorse's account. These problems are delineated in Chapter 4.

(4) Some may object to the example on the grounds that gambling is a disease and one is not responsible for his actions under this circumstance. Assume for the present that this is not a problem. However, I do not deny the difficulties with describing and categorizing such conditions. See chapter four for a relevant discussion.

(5) Medicine's adoption of disease as defining of its domain is clearly seen if a textbook of medicine is reviewed. Health is rarely, if at all mentioned, and the entire text is a discussion of sign, symptoms, etiologies of diseases.

(6) The movement in nursing to the normative model of disease explanation has occurred over the last two decades. It is
no coincidence that as nursing has attempted to define itself, its conceptualization of health and disease has changed. Before Nightengale introduced the environment into the patient-health-nurse equation, nursing's view of health was oriented by a concept of disease as an "intensive, pathological body process, one to be vanquished by vigorous, directed nursing activity" (Bandman and Bandman, 1981, p. 677). Nightengale introduced the notion that nursing's role was to place the "patient in the best condition for nature to act upon him" (Notes on Nursing: What It Is and What It Is Not). Over the last twenty years nursing has moved from an emphasis on disease and illness to an emphasis on health and well-being. Nursing has accepted a broadened definition of health. Parse, in her 1987 book, Nursing Science describes this movement to a broader definition of health. In the totality paradigm, health is viewed as being a dynamic state and process of physical, psychological and spiritual well-being. Notice that this paradigm already reflects a shift from the traditional medical model of health as absence of disease. This paradigm provides a framework for the present holistic approach in nursing. However, nursing has not stopped at this level—theorists have continued to broaden the definition of health until it clearly falls within the normative model. Parse states, "Health is viewed as a process of becoming and as a set of value priorities. Health is man's unfolding."

Why has nursing chosen this route—why work within this normative model of health? I think there are two reasons for this shift to the normative model. First, nursing has and is struggling with its own identity—or perhaps more accurately stated, to establish its independence from medicine. To establish this independence philosophical ties with medicine have had to be severed. Medicine is seen as the discipline interested in diseases and disease treatment. If nursing is to establish some independence it needs its philosophical orientation to be totally removed from medicine—that is totally removed from any dependence upon a relationship to disease and disease treatment. If nursing had accepted the definition of health as absence of disease a clean break with medicine would have been impossible. Instead nursing choose to focus on health, health defined very broadly so that it is more than mere absence of disease.

The second reason is discussed in chapter four—to legitimate intervention by nursing it has to be health related.

(7) The complete definition/account adopted by the World Health Organization on July 22, 1946 is the following:
Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.
The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.
The achievement of any State in the promotion and protection of health is of value to all.
Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger. Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of people.
Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

(8) The status of premenstrual syndrome has recently been the subject of debate. This debate has been fueled by its successful use as a partial defense in a British murder trial. This example and the other legal decisions are pointed out in a paper by Christopher Boorse (1987).

(9) More specifically, Boorse's account is simply that functions are contributions to goals. He claims that his analysis is guided by the following idea:

To say that an action or process A is directed to the goal G is to say not only that A is what is required for G, but also that within some range of environmental variation A would have been modified in whatever way was required for G (Boorse, 1976, p. 75).
Boorse addresses the issue of multiple goals. The problem is that a process may bring about several ends—for example, the cat's behavior may catch both birds and cream. How is one to determine the "true goal"? Boorse gives a contextual answer.

The function of X is Z means:
that in some contextually definite system S with contextually definite goal(s) G, during some contextually definite time interval t, the Z-ing of X is the sole member of a contextually circumscribed class of functions being performed during t by X in the G-ing of X—that is causal contribution to G. (Boorse, 1976, p. 81)

Boorse thinks he has been successful in getting what he wants—an account of functions that will allow the physiologist to use functional talk. The goal directed system is the individual organism and its goals are its own survival and reproduction.

Objections to Boorse's account have generally focused on its handling of artifacts (see Patrick Grim's paper, "Further Notes on Functions" in Analysis, Vol. XXXVII, p. 169-176). Boorse attempts to give an account of functions applicable to artifacts that is independent of a designer. The problem with Boorse's account according to Grim is that we could never decide whether something had a particular function without knowing whether it ever would so function.

(10) Hempel, in his "The logic of Functional Analysis", has made this example a classic.

(11) Though it is interesting to note that Boorse believes that diabetes is a disease when the physiological basis is a lack of production of insulin and depression does not have a physiological base when it too is caused by a deficit of a particular substance. In a latter section I argue that this difference points out a major weakness in Boorse's theory.

(12) Actually the data shows that Boorse's example is not right. The primary hypothesis to explain depression claims that there is a deficit of biogenic amines at the central adrenergic receptor sites. This is caused by a dysfunction at the cellular level in either the manufacture or depletion of these amines.
(13) Don Hubin first pointed out the distinction of health being a dispositional property.

(14) I agree with Rawls that the principle of justice must apply to the basic framework of society and not to individual transactions. Thus, when discussing health care distributuion, I do not believe that some sort of extraordinary or special obligation must be assumed by the providers.


(16) Each of these conditions incorporates a reasonable requirement. This is to rule out a host of counterexamples that could be raised to the conditions otherwise. For example, some individuals, because of mental handicaps, may not be able to know under the same conditions that most can, or an acceptable set of alternatives may be open, but this is unknown to the individual.

(17) A recent incident highlights this problem. A child was in need of a liver transplant and through media efforts was successful in receiving one. However, the liver was rejected; an appeal went out for a second transplant and the child received it. Unfortunately this liver too failed, so an appeal for a third liver was made. The problem here is that there are several individuals waiting for livers and the probability of rejection raises significantly after one organ has been rejected. The difficult issue of should the child receive the third transplant was never articulated. The chances of success by this time were quite small and the probability of success if given to another party much higher.

(18) In fact the Health Care Financing Administration (HCFA) is following such a policy. In 1986 HCFA passed regulations that limit the reimbursement for medical education for subspecialities.

(19) There is evidence that this has already occurred. Very little progress has been made in treating lung cancer. Some suggest that this is due to lack of funding and interest in researching and treating an almost preventable disease. The major problem with this in our present system is that such a policy will eventually make our present system even more unequal. Lifestyle changes for the better are almost solely
limited to the middle and upper classes. If the poor are not given adequate resources to change these lifestyle habits, such diseases will become limited to the poor. Not only will they not receive the services that would help prevent such illnesses, they will not receive treatment once these diseases occur.
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