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## List of Abbreviations

ADA	Americans with Disabilities Act
AHRQ	Agency for Healthcare Research and Quality
ASD	Autism Spectrum Disorders
CBA	Cost-benefit analysis
CDC	Centers for Disease Control and Prevention
CEA	Cost-effectiveness analysis
CESCR	Committee on Economic, Social, and Cultural Rights
CHP	Community Health Program
CMA	Cost-minimization analysis
CMH	Commission on Macroeconomics and Health
COI	Cost of illness
CSDH	Commission on Social Determinants of Health
CUA	Cost-utility analysis
CV	Contingent Valuation
DALYs	Disability Adjusted Life Years
DRG	Diagnostic Related Group
EEOC	Equal Employment Opportunity Commission
FDA	Food and Drug Administration
FEO	Fair Equality of Opportunity
FFS	Fee-for-service
GDP	Gross Domestic Product
HMO	Health Maintenance Organisation
HSA	Health Security Act
HSC	Health Services Commission
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	Institutes of Medicine
ITA	Incompletely Theorized Agreements

## List of Abbreviations

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MSUD	Maple Syrup Urine Disease
NIAID	National Institute of Allergy and Infectious Disease
NICE	National Institute for Health and Clinical Excellence
NIH	National Institutes of Health
NORC	National Opinion Research Center
OC	Overlapping Consensus
OECD	Organization for Economic Co-operation and Development
QALYs	Quality Adjusted Life Years
SAVE	Saved Young Life Equivalent
SCCMETF	Society of Critical Care Medicine Ethics Task Force
S-CHIP	State Children's Health Insurance Program
WHO	World Health Organization
WTA	Willingness to Accept
WTP	Willingness to Pay



## Introduction

Health systems throughout the world offer mixed results for their populations, both in terms of health outcomes and access to the conditions enabling individuals to achieve good health. Many health systems throughout the globe, the American health system most particularly, paradoxically produce both therapeutic gains and major discrepancies in access to quality care. Medical advances have improved patients' lives dramatically, yet stark inequalities in access, quality, financial burdens, and resource priorities undermine the impact of technological and scientific progress. The cost of health care is also on the rise (G. Anderson et al. 2000). Although providers, ethicists, health-policy experts, and government officials have attempted to address these issues many times, few proposals for reform have succeeded in many countries, notably the United States. In the United States, the failure of the Clinton Administration's 1993–1994 health reform efforts illustrates the problem's complexity. Physicians increasingly face the ethical dilemma of restricting access to necessary medical care when health insurers, state governments, and managed care organizations make, or require them to make, rationing decisions. Moreover, a 2004 United States Supreme Court ruling denies many patients any real recourse in suing their health maintenance organizations (HMOs) for denial of care (*Aetna Health Inc. v. Davila*, 2004). There is little consensus in the American health system<sup>1</sup>, as in health systems in many other countries, about how to ensure equal access, finance health care, allocate scarce resources, or define a benefits package.

Traditional bioethics and public health ethics offer numerous approaches to address these issues, which have generally, though not exhaustively, fallen into five categories—welfare economic and utilitarian schemes, libertarian theories, communitarian approaches, procedural or democratic frameworks, and egalitarian theories. These broad categories have begun to

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form a collection of approaches to bioethics and public health ethics, each with advantages and limitations when applied to the problems health systems face.

This book proposes an alternative theoretical framework for the more comprehensively defined area of health ethics, policy, and law, integrating both substantive criteria and procedural mechanisms—a joint scientific and deliberative approach—to guide health system development and reform and the allocation of scarce health resources. This theory incorporates a particular vision of the good life rooted in the capability approach<sup>2</sup> and Aristotelian philosophy (Irwin 1999; Lord 1984; Nussbaum 1990b; 1992; 1998). It builds on and integrates both Aristotelian and capability perspectives to develop a theoretical framework for health ethics, policy, and law, and to elucidate its public policy implications. The capability approach is, however, vastly underspecified (Pogge 2002b), so this book moves significantly beyond the roots and the minimalist interpretation of the capability approach and specifies and brings together numerous disparate ideas into a coherent view of health and social justice.

In this view, the ethical principle of ‘human flourishing’ underlies society’s obligation to maintain and improve health capabilities. This principle holds that society should enable human beings to live flourishing lives (Nussbaum 1990b; Irwin 1999). Flourishing and health are essential to the human condition. Certain aspects of health, in particular, undergird other areas of human flourishing, because without life itself, no other human functioning is possible. Therefore, public policy should focus on individuals’ ability to function. Health policy should support individuals’ capability for health functioning, enabling individuals to meet health needs, and creating conditions for health agency (Ruger 1997; 1998; 2004a).

From this perspective, expanding freedom is both the primary end and principle means of public policy; consequently, public policy should focus on removing barriers to freedom that leave people with little choice to exercise their reasoned agency. Freedom entails both processes of action and decision-making and actual opportunities available to people, given their personal and social circumstances (Sen 1999, p. 17). In what follows, I will argue that both the process and opportunity aspects of freedom are essential to developing individuals’ health capabilities and a just health system. Public policy should also be efficient, requiring the wise and prudent use of resources. The primary goal for health systems is to reduce disparities in health capabilities using the fewest resources. Therefore,

some limits must be set in allocating resources, and individuals and experts must decide how to make these trade-offs.

This theory offers several unique features and principles for health ethics, policy, and law.

## Theoretical foundations

### *Human flourishing and health capability*

First, this theory is rooted in a particular view of the good life: human flourishing, which values health intrinsically and more highly than non-intrinsic or solely instrumental social goods, such as income. This view gives special moral importance to a concept here called 'health capability'. Health capability, a person's ability to be healthy, includes health functioning and health agency (Ruger 1997; 1998; 2004a). It also implies that certain aspects of health are prerequisites for other types of functioning, including one's agency, or the ability to lead a life one has reason to value. Capability describes what individuals are able to do and be, offering a realistic sense of their real freedom to pursue the lives they value. Health capability broadens the scope of social justice and health policy to include health functioning and health agency, but it does not broaden it so much as to include all of what quality of life or well-being might entail.

### *Social choice theory and health capability*

A second major difference between this theoretical framework and those of others centres on the theoretical and methodological approach to collective choice. There is considerable focus in the bioethics and public health ethics literature on democratic procedures for decision-making about health and health care. In espousing a substantive end of health capability in this theory, I address two significant questions:

- (1) how to obtain actual collective agreement on a dominance partial ordering of health capabilities; and
- (2) what type of social decision-making might apply in such an exercise.

This phase of the work draws on social choice theory and argues that incompletely theorized agreements (ITA) hold promise as a complementary framework for the Aristotelian and capability views and provides a

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useful approach to collective decision-making in health and health policy. Here I build on previous work in legal decision-making by extending ITA in at least three respects: moving beyond judicial decision-making to broader societal and public policy decision-making; specifying the framework to health and health care decision-making; and combining ITA with the capability approach to advance the operationalization of the capability perspective. ITA thus picks up where the capability approach leaves off, and provides a framework for resolving conflict among divergent views. More specifically, health and health capabilities are multidimensional concepts about which different people have different and sometimes conflicting views. No unique view of health exists as the basis for all evaluations of health and social justice. The incomplete ordering of the capability approach, in combination with the incompletely theorized agreement on that ordering, allows for reasoned public policy development and analysis in the face of plural goods and different, even conflicting, views.

### *Trans-positionality and prioritization among health capabilities*

A third unique aspect of this theory is the development of a model that values 'central' health capabilities above those that are secondary. Central health capabilities are, simply, the capabilities to avoid premature death and escapable morbidity. This model reflects an incompletely theorized agreement on core dimensions of health capability. Agreement on the importance of providing such core health capabilities offers guidance in prioritizing health resources (Ruger 1998; 2004a; 2006a). These central features represent universally valued elements of health capability and offer a clear, grounded, and agreed upon view. This model includes both *potential* health and *actual* health—a duality embedded in health capability. It provides a middle ground or shared standard for health assessment. As such, it is useful in determining how we might go about assessing health policies and interventions and making comparisons among different individuals and groups. This model of health capability, which forms the foundation for prevention and treatment, provides a workable distinction between health-related needs and the goods and services that address those needs. This book offers a universal conception of health capability, while still maintaining room for further specification. This approach can help determine whether a particular public health or health care intervention or technology merits societal resources.

*Inequality and health: equality as the standard*

Fourth, while theories of justice have put forward a number of normative principles (equality, sufficiency, and priority) for treating people as equals in society and there are a number of different approaches to conceptualizing and measuring equality in bioethics and public health ethics, this approach employs 'shortfall equality' to judge public policies affecting health. The shortfall notion has been used in welfare economics and holds promise for the conceptualization and measurement of health inequalities. Shortfall equality compares *shortfalls of actual achievement from the optimal average* (such as typical longevity or physical performance). Alternatively, the concept of shortfall equality can also assess health capabilities, especially when equalizing achievements for different people is difficult. Human diversity is so pervasive and consequential, and can prevent some people from achieving maximal health. This approach might be particularly relevant for assessing the health capabilities of people with disabilities because it accounts for differences in the maximal potential for health functioning without 'levelling down' achievement goals of the entire group. Moreover, shortfall can be measured in either absolute or proportional terms, allowing proportional weighting for people with severe disabilities or, at the international level, weighting for countries with significant health deprivations. Shortfall equality is also more consistent with the emphasis on health as optimal functioning, 'a group's capacity to cope with all the circumstances of living . . . at an optimum level' and with 'freedom from the risk of disease' (Stedman 2000, pp. 789–90). This approach can also justify having good health as an end goal of public and health policy if we acknowledge that it is impossible to guarantee good health or equal health to everyone. The philosophical and pragmatic task of constructing an equality standard and measure for comparing individual advantage and disadvantage has been neglected in prior work on justice and health care.

*Ethical commitments and public moral norms*

Fifth, because the achievement of equity in health requires social organization in the form of a redistribution of resources, and related legislation and regulation, this obligation requires an ethical commitment on the part of everyone, those most fortunate and those in need, to the end goal of providing health capability to all. Without this ethical commitment, redistributing resources from the wealthy to those less fortunate and from the well to the sick will not be possible, because the effort to do so must be

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voluntary, not coercive. As such, individuals must internalize the public moral norm that health is worthy of social recognition, investment, and regulation to the point of successfully operationalizing it. The ethical imperative of health equity provides strong grounding for individual and state action to respect, protect, and fulfil health equity through institutional change. The primary means for achieving justice and actualizing a right to health are both legal and non-legal instruments. This ethical commitment to health equity is an ethical claim, in this case on all individuals, especially the wealthier, to redistribute some of their resources to help meet our own needs and those of others, today and in the future.

### *Ethics of the social determinants of health*

Sixth, there has been much discussion of how social factors or determinants that bear on health fit within an overall theory of bioethics or public health ethics. Efforts have generally either supported or opposed a 'separate spheres of justice' view, whereby it is legitimate to focus on justice in bioethics or public health without reference to justice in other domains of public policy. Those who reject this view claim that justice in bioethics or public health ethics cannot focus specifically on health, but must also address the many overlapping determinates affecting overall well-being, not just health. This approach is much more nuanced than these alternative perspectives. While recognizing that a number of policy domains influence health, I argue that we are far from understanding the precise societal mechanisms that influence health or how to weight different social objectives. Thus, even in light of existing information on social determinants of health, it is unwise to attempt to improve health with broad non-health policies, such as completely flattening socio-economic inequalities, as prescribed by some. Such prescriptions cloud rather than clarify the means and ends of health policy and our ability to evaluate the impact of public policy on health. Moreover, the social determinants of health must come together at the individual level.

### *A joint scientific and deliberative approach*

Seventh, the health capability paradigm involves a joint scientific and deliberative process, integrating substantive and procedural principles, as a resource allocation framework. This public process combines the evidence base of health care and public health with input from individuals,

physicians and public health experts to assess the value of treatments, medications, and other health care and public health interventions. Under this view, health care and public health are special (and therefore socially guaranteed) because they play a dominant role among determinants of health capability. It is important to assess both the necessity and the appropriateness of a health intervention. Medical appropriateness is a key principle of this approach. Although individuals have primary authority for health care decisions that affect them directly, physicians can help determine 'medical appropriateness' and 'medical necessity'. In this framework, individuals employ their health agency, and physicians seek their patients' best interest. Physicians and public health experts share knowledge and resources (e.g. benefits, risks, costs) with each other and with lay persons to achieve ethical rationality and practical reasonableness, balancing technical rationality with ethical rationality in collective choice—a more expansive account of rationality incorporates both. This approach provides for public deliberation through collaborative problem solving among physicians, public health experts, and citizens. These formulations focus especially on reasoning—whether at higher levels of abstraction or lower levels of particulars—and on mutual respect among citizens and experts. This approach stresses that participatory decision-making is instrumentally important for forming values and setting priorities when policy choices are difficult, but it does not rely on 'fair procedures' to determine fair outcomes. Rather, this theoretical approach is substantive in nature, incorporating participation and voice, but ultimately evaluating health policy in terms of its consequences and effects on health capability. This framework integrates both consequential and procedural elements of justice, unlike allocation theories resting on procedural justice alone. When policies and law require even greater specification, further iterations of public discussions could be necessary to make difficult choices about which health services merit societal investment.

Public policy cannot result from narrow technical blueprints. Rather, this theory envisions a stepwise process that reviews scientific evidence about the consequences of policies on health. Individuals must therefore have the capability to participate in such deliberations and decision-making and know the risks, benefits, and costs of health prevention and treatment and various health policy options. The deliberative process should also update its recommendations continually to account for changes in medical knowledge, technology, and costs when determining what probability of success would make an intervention worthwhile.

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### *Shared health governance*

Eighth, in this theoretical approach, decisions are made by appealing to a shared concept of ability for health functioning. When disagreements occur, practical models of agreement or consensus facilitate workable solutions. The resolutions that flow from these deliberations offer guidance in standardizing prevention and treatment decisions and developing health policies and health laws. This view contrasts with paradigms in which consumers alone, physicians or public health experts alone, strict algorithms or cost-benefit calculations, shared decision-making within an informed consent model, fair procedures, or third parties (such as insurers) make health decisions. The underlying framework is *shared health governance*, a construct in which individuals, providers, and institutions work together to empower individuals and create an environment enabling all to be healthy (Ruger 1998; 2004a; 2006b). The shared decision-making of other approaches focuses narrowly on individual decisions in isolation, but a shared health governance model incorporates individuals' decisions for themselves and *for their society at large*. Shared health governance extends beyond the individual patient–doctor relationship to the institutions that oversee the health sector. This paradigm promotes consensus on substantive principles and procedures of distribution; offers a method for achieving that consensus (incompletely theorized agreements) (Ruger 1995a; 1997; 1998; 2004a); places importance on the results of health policies and laws (costs and effectiveness) in judging them; and promotes deliberation through collaborative problem-solving. Thus, the framework integrates both consequential (substantive) and procedural (democratic) elements of justice, and focuses on both health functioning and health agency. Both decision-making processes and achieved outcomes are important for evaluating justice. Neither fair procedures alone nor desired outcomes alone foster a just system.

## Applications

### *Rethinking equal access: agency, quality, and norms*

Ninth, a shared health governance model takes a different tack on the issue of equal access (Ruger 2007a). Equal access should mean equal access to high-quality care, not a 'decent minimum', 'adequate care', or 'tiered health care'. Equal access on this view does not imply equal outcomes or

equal results. Nor is it enough to provide health care without efforts to expand individuals' health agency—their ability to engage with and navigate the health system and their environment to avoid mortality and morbidity and to meet health needs (Ruger 2004a; 2007a). Furthermore, shared health governance means shared responsibility—individuals, providers, and institutions have respective roles and responsibilities in achieving health goals. A major emphasis of the health capability paradigm is that institutions and providers are morally obligated to provide as high quality health care as resources permit to all individuals (Ruger 2007a). It is unfair to deny any one individual, or group of individuals, access to quality care if doing so could substantially decrease their chance of a significantly improved health outcome. In policy terms, reaching this goal would require continuous efforts to standardize medicine, reduce medical errors, and move towards a gold standard of care (IOM 2001). High-quality care is not a modest universal criterion of social justice. It is a demanding criterion because it is necessary from a moral point of view for helping people to function at their best, given their circumstances. Its ambitiousness reflects the need to evaluate the impact of equal access policies on health (functioning and achievements) and health agency, taking into account individuals' health needs and disabilities. Such a view would not condone the significant disparities in health care quality that exist in the United States, for example, and in many developed and developing countries.

### *Responsibility and health: voluntary risk and paternalism*

Tenth, this theory seeks to enhance individual responsibility through improving health agency, as both are essential for achieving optimal health outcomes and creating a fairer health system for all. Any theory of health and social justice must address concerns of personal responsibility and voluntary risk. At first glance it appears that some people are not voluntarily risk averse to health consequences—smokers unconcerned about lung cancer, for instance. Some think people who knowingly take risks with their health should pay additional sums of money or be solely responsible for paying for health insurance and health care. Such a system, it is argued, would:

- (1) help raise additional financing for services caused by bad health habits; and

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- (2) help mitigate the moral hazards of such situations by giving people incentives to change their habits.

However, these perspectives suffer from several shortcomings. It is difficult at this juncture to understand the respective causal determinants (including genetic determinants) of, and differences between, voluntary versus involuntary contributors to health risk. As such, it is unjust to always blame individuals for their health problems. That said, improved health agency and health functioning—through public policies that rely on principles ranging from paternalism to libertarian paternalism to free will—at one point in time and over time can impose greater responsibility on individuals to make healthier choices and ultimately improve their health.

### *Moral foundations of health insurance: preventing, mitigating, and coping with risk*

Eleventh, understanding that universal health insurance is essential for human flourishing opens up an alternative moral framework for analysing health insurance. The United States and numerous developing countries do not provide universal health insurance coverage to their populations. Academic approaches to health insurance have typically adopted a neo-classical economic perspective, assuming that individuals make rational decisions to maximize their preferred outcomes, and businesses (including insurance companies) make rational decisions to maximize profits. In that approach, individuals who are risk averse will purchase health insurance to reduce variation in the costs of health care between healthy and sick periods. In empirical studies, however, individuals do not always make rational choices. They also find it difficult to assess their health risks and to know how much insurance they need. In contrast, bioethics and public health ethics have focused on the issue of equal access to health care, but provide little in the way of philosophical justification for risk management through health insurance *per se*. Nor has either bioethics or public health ethics shown how risk-pooling, in which many at-risk individuals pay premiums to cover one individual's expensive health outcome, is ethically desirable, except insofar as it ensures equal access to health care and equal income to purchase it for all contributors. The central ethical aims of universal health insurance coverage are to keep people healthy, and to enhance their security by protecting them from both ill health and its economic consequences, issues not adequately considered in the bioethics

and public health ethics literature to date. Universal health insurance that is community-rated and progressively financed is critical because equal access cannot be separated from equity in health care financing.

### *Market failures, public goods, and the role of the public sector*

Twelfth, health care and public health financing, delivery, and organization can involve either private (profit or non-profit) or public entities or a mix of the two. The approach taken in this book is that society must compare the advantages and disadvantages of the free market with those of the government and other political and social institutions. This view transcends systems that are either primarily capitalist or socialist. In the health care and public health sectors, numerous market failures have created a rationale for public sector involvement. Epidemics are one of the most common causes of health care market failure; preventing and controlling them requires public health programmes. Public goods—those whose benefits should extend to everyone and whose consumption by one person does not preclude consumption by another—also require public financing, because private markets typically will not produce goods they cannot sell exclusively to one person. There are also mixed goods that benefit specific individuals but have societal benefits as well. Rehabilitation services, for example, improve patients' physical functioning but also enhance economic progress through better labour productivity. Another market failure in health care is information asymmetry, in which health providers or insurers have significantly more information about a patient's condition than the patient does or vice versa. The drawbacks of an entirely public health sector or an entirely private health sector suggest that mixed public-private systems might be optimal. Market failure types suggest a greater role for public financing and private provision through non-profit institutions. The health capability paradigm proposes a blended approach to create an integrated and multifaceted system, in which different types of institutions work together to improve health capability. To create and maintain equitable and efficient health systems, governments must offer significant direction, oversight, regulation, financing, and, in some cases, provision of care. In many settings, however, the private sector can provide goods and services effectively in conjunction with a supportive and regulatory public sector. In virtually every area of the health sector, public-private collaboration and investment are critical, especially in generating medical knowledge, technologies, goods, and services.

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### *A robust concept of opportunity costs: incorporating efficiency*

Thirteenth, this paradigm takes a stepwise approach to resource allocation whereby economic considerations follow and complement clinical input, not vice versa. Evaluation of health policies, laws, and technologies must consider costs because we live in a world of scarce resources. Moreover, every resource has an alternative use, so its expenditure corresponds with an opportunity cost. Therefore, some limits are necessary, and individuals and society, through shared health governance, must use these resources parsimoniously by evaluating efficiency. Efficiency measures include cost-minimization analysis (CMA) and economic incentives for high-quality care. Cost-effectiveness analysis (CEA) can also be useful in comparing interventions for a single population, such as AIDS patients, by weighing the marginal benefits and marginal costs of two alternative interventions. For example, evaluating the cost-effectiveness of combination antiretroviral therapy for HIV infection, or of preventing AIDS-related opportunistic infections (Freedberg et al. 1998; 2001), or simulation modelling of lifetime costs and life expectancy to inform clinical guidelines for the treatment of HIV-related *Pneumocystis carinii* pneumonia (PCP) can help identify the additional costs society must pay for the additional benefits of each intervention.

Most approaches to bioethics and public health ethics fail to consider opportunity costs and efficiency adequately. The consideration of costs under this theory resembles a utilitarian welfare economic perspective in that costs and outcomes are both valued. However, it contrasts with the utilitarian aggregation methodology and recommends the use of cost-minimization analysis and cost-effectiveness analysis in combination with equity-oriented allocations (as opposed to incorporating equity weights into CEA). In addition to helping physicians and patients judge whether a particular medical intervention or technology merits investment, CMA and CEA can reveal financial reasons for basic health care inequalities. For example, some American oncologists profit by purchasing chemotherapy agents and dispensing them at a much higher price, which leads to inefficiency through higher pricing and over-use, particularly at the end of life (Emanuel et al. 2003). This practice also compromises a physician's duty to act in a patient's best interest.

*Disabilities and reasonable accommodation*

Bioethics and public health ethics have struggled to address disabilities and severe physical and mental impairments in societal decision-making about health care and public health. The health capability paradigm argues for basing judgements on joint patient–physician decision-making (at the policy and individual levels), using medical necessity, medical appropriateness, and medical futility as criteria, rather than attempting to estimate specific weights for severely disabled individuals, as other frameworks do. Thus, this paradigm aims to protect disabled people from discrimination while limiting exorbitantly costly care that would deprive others of necessary health resources.

**Normative theory and health policy decision-making**

*Norms and values in the public’s assessment of policy*

Another unique aspect of this theory of health and social justice is the extent to which it grapples with domestic health reform and the question of the interplay between political and moral legitimacy. A theory of health and social justice must not only present a morally legitimate conception of the good, but also offer a convincing framework for its political legitimacy and thus ultimately its implementation through political processes and social institutions. Thus, while the theory of health and social justice presented here claims that justice requires relieving shortfall inequalities in central health capabilities as efficiently as possible (as a demand and principle of justice), it also seeks a balance between state interference to achieve these goals and individuals’ freedom from interference (right to non-interference). As such, this theory also commits to the idea that, through public reasoning and democratic practice, individuals internalize public moral norms of redistribution and state oversight and willingly embrace ethical commitments to offer political legitimacy to this goal. The final part of this book examines the role of norms and values in public policy decision-making and offers a normative theory of health policy decision-making. This work is based on the premise that in order to achieve changes in health policy at the national level in any country through a politically legitimate democratic process, citizens must be willing to pass federal legislation with moral legitimacy that ensures equity in health for all. This final part of the book presents a normative theory for

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analysing federal health policy decisions, with specific application to the United States. The goal is to advance a health reform approach that analyses the role of values and norms, particularly their level of generality, in health policy decision-making, and the extent to which different policy actors (political and non-political) internalize norms themselves and attempt to produce coalitions around them. Prior work on public values in health policy has overlooked the ways in which values of different levels of specificity connect to create a coherent (or incoherent) rationale for health reform. This book aims to address these gaps by using a more accurate framework of social agreement, which reflects the fact that values and norms operate at multiple levels of generality and degrees of internalization. In so doing, it provides a better understanding of how norms and values work together to form a coherent (or incoherent) basis for reform. This alternative framework, social agreement theory, builds on political philosophy and legal theory.

### *Public moral norms and domestic health reforms*

The normative framework presented here is unique in that it integrates public moral norm internalization and the social agreement model of incomplete theorization. A ‘public moral norm’ is a moral value that pertains to our individual and collective morality in the public sphere; an example of such a norm would be collective organization to achieve common goals. A public moral norm contrasts with an individual moral norm in that the moral value pertains not just to individual action but also to collective action regarding the public sphere (e.g. norms about procedural justice, rules of accuracy, trust, ethicality, and neutrality). A particular type of public moral norm, a distributive justice norm, determines the distribution of societal resources. The consistent failure of health care reform efforts in the United States can be understood by first analysing the extent of individual, societal, and political internalization of necessary public moral norms—for instance, that one has an ethical commitment to make financial sacrifices to support the expansion of health insurance—and then determining the extent to which social agreement about this ethical commitment has occurred. This agreement could occur even without consensus on abstract higher-level principles and on principles in other domains of social life (e.g. welfare). When this norm does become internalized, domestic legislation can follow. The failure of health care reform in the United States shows that it will be difficult for America to adopt universal health insurance coverage until this norm of willingness

to pay for others' health care coverage gains acceptance at the social and political level. Without this norm's acceptance, efforts to achieve public consensus on abstract principles (e.g. equality) or on 'universal coverage' will continue to be stymied because they create more disagreement than agreement. Americans, especially liberal Americans, experience considerable ambivalence and conflict among the abstract higher-level principles invoked in debates about universal coverage. The theoretical framework developed here illustrates how these cleavages and uncertainties work and how they allow opponents of reform to launch value-based arguments that disrupt reform-supporting coalitions.

### *Internalization and agreement on moral values*

The theory developed here offers promise for analysing health reform efforts in many countries, especially pluralistic constitutional regimes. Drawing attention to coalitions around, and internalization of, values and norms offers insights and prescriptions distinctive from those that prevailing analyses provide. From this perspective, pluralistic constitutional regimes are composed of individuals and their representatives, whose diverse beliefs create social tension and make social agreement difficult to achieve. Therefore, attempts to make collective decisions—for example, through the legislature—must emphasize shared values to achieve stability and social unity. It is necessary to determine shared values, even values that are shared for different reasons, to achieve social agreement for political and legal decision-making. From this perspective, legitimate political authority is not just a matter of political philosophy; it has pragmatic advantages in forging consensus and coalitions amid pluralism. In this way, this theoretical framework helps further traditional political process and bargaining arguments because it illuminates how political actors can undermine the conditions for reasoned agreement on common interests. It challenges the current scope of public opinion research in that it calls for research probing aspects not addressed in most prior studies, aspects connecting values to support for policies. Furthermore, it calls for research to examine whether the conditions of public communication help produce an informed, reasoning, and deliberative public that can come to agreement on norms and values for policy. Moreover, this framework relies on popular sovereignty and political leadership to enhance deliberative public debate and public reasoning in order to agree on the common good. Finally, this approach recognizes that efforts to address health problems in developing and developed countries alike

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will probably require norms and values to be restructured in a fundamental way—globally, but most importantly, at the national level. Social movements at the national level, such as the civil rights and feminist movements in the United States, for example, have provided momentum and principles for such restructuring.

Collective reasoning about public policy requires a truthful deliberative process and a sincere and dedicated effort to achieve consensus on both the ends (values) and means (acceptable policy solutions) of public policy. These efforts are critical to citizens' ability to 'rule themselves' (Richardson 2002). Public opinion can be manipulated and distorted, so the challenge in a constitutional democracy is to create the conditions under which individuals can agree on a political conception that governs health and health care. Such a conception is likely latent in the political culture and might well emerge through public deliberation and social consensus. Efforts to involve national governments in improving the health of their populations and to ensure access to quality health care for all require more than fragile agreement on mid-level principles. These efforts require invoking principles, values, and norms, as well as honest discussion about the consequences of denying necessary and appropriate care for people's health and security.

## Notes

1. Health system includes health care, public health, and health-related research.
2. Martha Nussbaum and Amartya Sen provide different versions of the capability approach. Here both perspectives are drawn on, although I focus more heavily on Sen in developing theory. See generally Sen (1992; 1999). For more on the differences between Nussbaum's and Sen's versions of the capability approach, see generally Nussbaum (2000b).