

Introduction

My goal in *Just Health: Meeting Health Needs Fairly* is to present an integrated theory of justice and population health, to address a set of theoretical and real-world challenges to that theory, and to demonstrate that the theory can guide our practice with regard to health both here and abroad. A theory of justice and health must tell us what we owe each other in the protection and promotion of health. To do that, it must explain the moral importance we place on health, it must tell us when differences in health are unjust, and it must guide our thinking about meeting health needs fairly when we cannot meet them all. The answers to these questions are not just theoretical, for they pervasively underlie controversies about health policy and the design of institutions that impact population health. For such a theory to be integrated, the answers to these questions must fit together in a coherent way. Such a theory is validated or tested by examining the way in which it responds to both theoretical and real-world challenges to its central features. It is also tested by the adequacy of the guidance it gives to our practice in promoting and protecting health. My goals are clearly ambitious, but they did not emerge overnight. They accumulated in the course of a long journey that I shall describe.

MY JOURNEY

Just Health: Meeting Health Needs Fairly is the result of an odyssey – physical and intellectual – that began when I published *Just Health Care* over two decades ago. This sequel elaborates in new directions the population view of justice and health that I began to develop in the earlier work, but it is very much the product of my encounters with more practical challenges posed by the wider world of health. Fortunately, my journey was guided by wise collaborators without whom my ideas would never have survived and evolved. I begin my narrative at its starting point, the launch of *Just Health Care*.

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Since its inception, much of bioethics has focused heavily on important features of the dyadic relationship between doctors and patients or research subjects, or on the potential benefits and risks for those individuals that arise from new technologies, a rich, exotic terrain for ethical exploration. As a political philosopher trained originally in the philosophy of science, I began to write *Just Health Care* with a different, more theoretical and abstract, goal in mind. I thought we could use what I considered to be widespread agreement on how to distribute health care equitably as one way to test which general theories of justice best accounted for that presumed agreement. I quickly discovered that my strategy was naive and that much preliminary work had to be done in order to understand what justice in health means. As a result, *Just Health Care* provided a seminal examination of the social function of health care, broadly construed to include traditional public health and medicine. It focused on social obligations to promote population health and distribute it fairly through its distribution of health care. Like this sequel, it was concerned with more than the benefits that individuals get from public health and medical interventions. Like this sequel, it was concerned with more than the distinctive relationship through which doctors help deliver those medical benefits to individuals who need them.

Yet, the population perspective in *Just Health Care* was partly hidden. Although I had characterized health care broadly to include traditional public health, even devoting two long chapters to occupational health, many of my examples were about medical services. Nor did the title help: “health care” means “medical care” to most people. Not surprisingly, most people then read the book as focused on medical care. The import of focusing on health systems and their impact on populations rather than on individuals was thus blunted. Through my work on priority setting, health system reform, and the social determinants of health, I learned that this limitation of the book was not simply a problem of execution, the result of a focus on the wrong examples. It came from a deeper failure to understand the full dimensions of a population view. My journey taught me that I must seek answers to a broader set of questions.

One central question dominated *Just Health Care*. What is the special moral importance of health and health care? Connecting the answer to that question to prominent work in the general theory of justice was a first step toward articulating a population view since it pointed to the grounds for our social obligations to promote population health and distribute it fairly. Specifically, health is of special moral importance because it contributes to the range of exercisable or effective opportunities open to us. I understand health to mean normal functioning – the absence of significant mental or physical pathology. Maintaining normal functioning through public health and medical interventions thus makes a limited but significant contribution to the range of exercisable opportunities open to people. While opportunity is a good enjoyed by individuals, protecting the space of exercisable

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opportunities is a societal obligation that creates a public good enjoyed by a population. If we have obligations of social justice to provide equality of opportunity, as in Rawls's robust notion of fair equality of opportunity, then we have social obligations to promote normal functioning and to distribute it equitably in society by designing our institutions properly.

I had high hopes that my answer to the question about the moral importance of health would guide us in resource allocation decisions. I thought that the impact of ill health on opportunity might tell us what we needed to know about the importance of competing health needs. The first stage of my odyssey disabused me of this hope by placing me face-to-face with real-world resource allocation problems.

In the late 1980s, I began to collaborate with James Sabin, a psychiatrist at Harvard Medical School and at the Harvard Community Health Plan. We were interested in how health plans decided to cover one treatment and not another, considering this the tip of the iceberg of resource allocation. The issue of resource allocation – or rationing – had already emerged in U.S. health policy. In the 1980s, Medicare had instituted a prospective payment scheme, diagnosis-related groups (DRGs), which opened a debate about making hospitals and especially physicians act as “gatekeepers” of shared resources. In the late 1980s, Oregon began the process of “rationalizing” its Medicaid coverage decisions, initially using a methodology that ranked treatment–condition pairs by their relative cost-effectiveness. An early lesson of the Oregon process was that the public did not accept a straightforward health-maximizing strategy. At roughly the same time, in the late 1980s, a philosophical literature began to emerge about a set of “unsolved rationing problems,” as I later called them (Daniels 1993).¹ These problems were pervasive in health care: How much priority should worse-off cases get? When do minor benefits to large numbers of people outweigh significant benefits to fewer people? When should we give people a fair chance at some lesser benefit rather than invest in the best outcomes? An emerging social science literature later confirmed the view, apparent in the Oregon experience, that many people in various cultures were not straightforward health maximizers (Nord 1999; Dolan et al. 2005).

The collaboration with Jim Sabin took us deep into the decisions about coverage made by managed care organizations and other insurers. We began to understand that reasonable people will disagree about many of the coverage and priority-setting decisions that health insurers in the United States, public agencies in many countries, and even hospitals and local health authorities in many systems have to make. Our adventures in the world of managed care thus led me to see that a population view also required an answer to a distinct question of justice from the one that dominated *Just Health Care*. Now we asked: How can we meet health needs fairly when we

¹ Full references for citations in the text are contained in the References.

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cannot meet them all? More specifically, given moral disagreement about how to meet health needs, how can priority- or limit-setting decisions come to be accepted as fair and legitimate? Drawing on our initial answer to that question (Daniels and Sabin 2002), *Just Health* integrates our account of a fair process into the rest of my account and develops further its important theoretical and practical implications.

My second adventure brought me face-to-face with yet another central question for population health that I had earlier ignored. In the late 1990s, I became a Robert Wood Johnson Special Investigator. That Fellowship program brought me together with some of the leading American social epidemiologists. Their work on the social determinants of health and of inequalities in health across population subgroups led me to read more widely in the burgeoning field that emerged after I wrote *Just Health Care*. During roughly the same period, U.S. literature began to pay great attention to health inequalities or “disparities” by race. In addition, a growing global literature addressing health inequalities and describing practical efforts to redress some of them became prominent in the same period. After reading this work on health inequalities and their social determinants, I realized that I had pursued the question about the special importance of health – and derivatively of the factors contributing to health – too narrowly. In a collaboration with Bruce Kennedy and Ichiro Kawachi, two researchers at the Harvard School of Public Health, we examined the implications for justice of this literature.

These explorations with Kawachi and Kennedy led me to another key advance that *Just Health* makes over my earlier work, namely, the broader evaluation of all the determinants of health, not just health care or traditional public health. If health has special moral importance because of its impact on opportunity, then these other determinants of health have special importance comparable to that of health care. The broad determinants of health and its distribution in a population include income and wealth, education, political participation, the distributions of rights and powers, and opportunity. These are quite centrally the goods that any general theory of social justice is concerned about. We cannot achieve effective promotion of health in a society as well as its fair distribution without a just distribution of these other goods. Putting together the key results from the social epidemiology literature with Rawls’s (1971) principles of justice as fairness, we learn why justice is good for our health and we get a general answer to the question “When is a health inequality unjust?”

The premise of the pun in the title of *Just Health Care* was that I could explain what justice required in health care without talking about all of social justice. I only had to appeal to widespread agreement with the importance of equality of opportunity. In *Just Health*, that premise is undermined, and the pun is replaced with some irony because social justice, broadly construed,

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promotes population health and distributes it fairly. I nevertheless kept the apparent pun in the title to signal continuity with *Just Health Care*.

The odyssey thus far taught me that my original theory failed to guide practice in significant ways because it had not answered crucial questions. By focusing too narrowly on medical care and traditional public health, rather than on broader determinants of health, the theory failed to give adequate ethical advice about how to reduce unjust health inequalities or even how to identify them adequately. By failing to provide an account of fair process, the theory gave little guidance about how to meet health needs fairly. In the next leg of my journey, my encounters with health system reform, I learned that the integrated population view incorporated in *Just Health* actually provides crucial guidance about the fairness of health reforms.

My experience with health system reform began when I was on the Ethics Working Group of the Clinton Administration Health Care Task Force. We were charged, among other things, with developing “principles” to govern the resulting reform. Before the Task Force convened, I had assembled a set of what I called “design principles” that seemed to be implied by my work on justice and health to that point (see Daniels 1995). The Ethics Working Group, after considerable discussion of the design principles, endorsed a set of principles that Dan Brock and I distilled from our discussion (Brock and Daniels 1994). Although the reform effort soon failed, Don Light approached me about converting my design principles into a matrix for evaluating the reform proposals that had been introduced in the 103rd Congress, and we worked with Ron Caplan to complete that task (Daniels et al. 1996). Our approach combined the ethical framework that had emerged from my thinking about justice and health care with operations research methodology. Measures were developed to assess whether the system was improved or worsened relative to specific goals or criteria – “benchmarks” – of fairness.

In 1998–9, at the urging of Julio Frenk, then head of Fundsalud, a Mexican think tank about health, and more recently the minister of health in Mexico, I collaborated with Jack Bryant and others in Pakistan, Thailand, Mexico, and Colombia to convert the American Benchmarks of Fairness into a generic international version that could be used in a range of developing countries (Daniels, Bryant, Castano, Dantes, Khan, and Pannarunothai, 2000). That version incorporated the broader focus on the social determinants of health with the emphasis on fair process in priority setting. In short, it put the theory in *Just Health* to work monitoring and evaluating health reforms. Since then, with funding from the Rockefeller Foundation, I have worked with Jack Bryant, Walter Flores, and many others to construct local adaptations of the Benchmarks for use in nearly a dozen countries on three continents (Daniels et al. 2005). These many small adventures have led me to conclude that the theory developed in *Just Health* provides

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practical guidance to those aiming at improved population health, which I take to be an important test of the view.

A MAP OF *JUST HEALTH*

My odyssey has shaped *Just Health* in structure and content. The following map should help readers find their way. Like Gaul, the book is divided into three parts. Part I lays out the integrated theory. Part II addresses three key challenges to it. Part III puts the theory to use and closes with a final challenge, this time to the reader.

Part I: A Theory of Justice and Health

In Chapter 1, I pose three central questions of justice and suggest how they are related: What is the special moral importance of health? When is a health inequality unjust? How can we meet health needs fairly when we cannot meet them all? I answer each of these questions successively in Chapters 2–4. Chapter 2 builds on my earlier opportunity-based account of the moral importance of health. I find a basis for linking health and opportunity not just in Rawls's (1971) theory of justice as fairness and its later revision (Rawls 1993, 2001), but also in competing accounts of justice (Arneson 1988; G. A. Cohen 1989, 2000; Sen 1992). In Chapter 3, I suggest that the social determinants of health, if governed by an account of justice such as that of Rawls, would significantly reduce observed health inequalities. This suggests that health inequalities are unjust when they result from an unjust distribution of the socially controllable factors affecting population health. In short, social justice is good for our health. In Chapter 4, I argue that we need to supplement an opportunity-based account of the importance of health with an appeal to procedural justice or fair process, since there remain distributive issues that are unresolved by the principle underlying our account of just health. Priority-setting decisions create winners and losers, and moral disagreements about them raise questions of legitimacy. I describe the conditions that must be met in order to achieve accountability for the reasonableness of priority-setting decisions. In Chapter 5, I describe some general implications of the resulting theory for prevention, for a right to health and health care, for disabilities, and for our responsibility regarding health. The answers to our three main questions provide an integrated view of these implications.

Part II: Challenges

Part II responds to three important challenges to the theory. Specifically, the theory must be compatible with the way we think about opportunity

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over the lifespan, with what we think about the importance of individual liberties, including the liberty to consent to risks, and with what we think about other moral obligations, such as those of physicians to their patients. There are theoretical and real-world aspects of each challenge. In Chapter 6, I consider whether an opportunity-based account of the importance of health can reply to the objection that it would be biased against the elderly, who may be thought to value opportunity less. This challenge is sharpened by the rapidity and magnitude of societal aging globally. Chapter 7 focuses on the conflict between public health approaches to reducing workplace hazards and traditional antipaternalist concerns about letting people consent to risks. In effect, we must consider whether public health is compatible with individual liberty to take risks. These antipaternalist concerns also play a prominent role in more recent disability rights legislation, posing another aspect of the real-world challenge. Chapter 8 explores how well my integrated account of justice fits with claims about the professional obligations of physicians. The challenge comes from the belief, intensified by recent efforts to have physicians play the role of gatekeepers in various countries, that obligations to patients cannot be reconciled with concerns of distributive justice, since these require physicians to act as stewards. The ability of my account of just health to respond to these challenges increases its plausibility.

Part III: Uses

Part III applies my theory to global issues of population health. One key contributor to population health and its fair distribution is the performance of its health system: How well does it pursue the objectives of justice in population health? In Chapter 9, I describe how the theory developed here guided work in developing the Benchmarks of Fairness, a tool for examining how well health sector reforms in low- and middle-income countries work to promote equity, accountability, and efficiency. Chapter 10 describes the relevance of accountability for reasonableness to two quite different problems in developing countries: the difficult task of selecting patients in the global scale-up of HIV/AIDS treatments – an approach endorsed by WHO/UNAIDS (2004), and decision making about the incremental expansion of a catastrophic insurance plan in Mexico. In Chapter 11, I show that efforts to reduce even unjust health inequalities, such as race or gender disparities in health, encounter the unsolved rationing problems noted earlier. The chapter argues that fair process must come to our rescue even when we know that an inequality in health is unjust. Chapter 12 draws on my collaboration with a human rights colleague, Sofia Gruskin, to argue that human rights approaches to health encounter the same priority-setting problems apparent from the perspective of distributive justice and would benefit from the same solution to them.

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A Concluding Challenge

The concluding chapter of the book poses a different kind of challenge from those taken up in Part II. It reminds the reader that an account of justice and health is a work in progress, and it poses the challenge of completing that work in a relatively new area of inquiry. From one perspective, the challenge it highlights is a limitation of my theory of just health, namely, that it fails to be specific about international obligations to promote health or reduce international inequalities. I prefer, however, to view the chapter as a challenge to readers or, more accurately, to the global community of which readers are a part. The chapter argues that some international health inequalities are matters for global justice, characterizes a stalemate in the philosophical work on this topic, and proposes a way forward in thinking about our obligations to reduce the inequalities. The challenge to readers is to complete my journey by developing that way forward into a full account of justice and global population health.

By connecting population health to broad questions of social justice, *Just Health* provides a rationale for an expanded focus for bioethics as a field. At the same time, it provides an ethical framework that the many dedicated workers who promote population health here and abroad can use to evaluate the many health policy issues they face. If this framework provides good guidance in thinking about health policy, as I believe it does, the theory will satisfy one important test of normative work. I advance it as a work in progress, not a finished product, a lesson made clear by the developments in my thinking about justice and health over the past couple of decades. I hope others will find ways to improve it so that we can all better understand what justice implies about health.

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PART I

A THEORY OF JUSTICE AND HEALTH

1

Three Questions of Justice

A FUNDAMENTAL QUESTION OF JUSTICE

As a matter of justice, what do we owe each other to promote and protect health in a population and to assist people when they are ill or disabled? I shall refer to this question about our social obligations as the “Fundamental Question” of justice for health.

My strategy for answering the Fundamental Question is to substitute for it three more specific “Focal Questions” (Daniels 2001):

1. Is health, and therefore health care and other factors that affect health, of special moral importance? To answer this question, we need to see how meeting health needs is connected with other goals of justice. Answering it may tell us whether we have obligations regarding health and its distribution within a population that do not apply to some other goods.
2. When are health inequalities unjust? To answer this question, we have to understand the factors and social policies that contribute to population health and health inequalities. The answer will help us understand which health inequalities it is most important to address.
3. How can we meet health needs fairly under resource constraints? Since health is not the only important good we pursue, resources are always limited. To answer this question, we must determine the source of our agreements and disagreements about priority setting. This will help guide policy under real-world conditions.

In this chapter, I shall explore each of these Focal Questions further, describe how the answers to them are related to each other, and explain how they fit together to form an answer to the Fundamental Question and thus provide us with a population view of justice and health. The Fundamental Question of justice, in the form of these three Focal Questions, underlies many controversial issues about health policy. My goal in this book is to