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Abstract

Several attempts have been made to apply the choice-sensitive theory of distributive justice, luck egalitarianism, in the context of health and healthcare. This article presents a framework for this discussion by highlighting different normative decisions to be made in such an application, some of the objections to which luck egalitarians must provide answers and some of the practical implications associated with applying such an approach in the real world. It is argued that luck egalitarians should address distributions of health rather than healthcare, endorse an integrationist theory that combines health concerns with general distributive concerns, and be pluralist in their approach. It further suggests that choice-sensitive policies need not be the result of applying luck egalitarianism in this context.

Luck egalitarianism is an influential theory of distributive justice. The theory has been described in several ways. One common account requires that the effects of luck, understood as the inverse of responsibility, be neutralized.[1–3] Another, non-equivalent account has it that "it is bad if some people are worse off than others through no voluntary fault or choice of their own." [4–6] The common feature of these accounts is the distributive significance they assign to the distinction between the chosen (associated with responsibility and the voluntary) and the unchosen (luck, or the absence of the voluntary).

It is sometimes argued that luck egalitarianism, with its focus on personal responsibility, can make a valuable contribution to our moral assessment in the complicated areas of health and healthcare.[7–11] There could be a practical need for such a contribution, since references to personal responsibility are frequent in policy discussion.[12–16] However, several writers remain unconvinced of such an application and have raised important critiques in that regard.[17–27]

A comprehensive application of luck egalitarianism in health and healthcare would presumably require a specification of what luck egalitarianism means. Due to the heterogeneity of the luck egalitarian literature, such a specification involves taking sides on several difficult issues. This would include (but not necessarily be limited to) how advantage should be measured, what constitutes choice, and whether we address only inequalities not reflecting those or also equalities.[10] We will not add to this vast literature here. Instead we present a framework to serve as a useful guide for applying luck egalitarianism (however construed) to health and healthcare. After setting out the framework we address significant

criticism of luck egalitarian approaches to health and healthcare, and finally deal with several real-world issues raised by such approaches.

Questions

In this section we consider some questions that we believe arise for all attempts to apply luck egalitarianism to health and healthcare. The theoretical choices presented in this section concern the normative core of such an application.

Health. When assessing the fairness of distributions in relation to health from a luck egalitarian perspective, which health-related goods should we ultimately be concerned with? One proposal is concerned with inequalities in people's access to (or opportunity for) healthcare. Such an account is thus attentive to unchosen differences in distance to hospitals, co-payments, treatment outcomes and other things related to the healthcare system. This position, which we could call the *healthcare view,* is prominent in much earlier work on distributive justice in this area.[9,28–30] A concern for healthcare has been defended on the basis of the benefits healthcare provides,[31] as reflecting the fact that delivering the just amount of health is not within society's control,[28] and on the grounds that treating people as equal involves supplying them with equal access to healthcare without considering the health effects of such a provision [29].The main alternative view is concerned with distributions of health as such. Inspired by the recurrent confirmation of the importance of social determinants to people's health,[32,33] this broader view means that sources of inequalities in health that are unrelated to the healthcare system are also a concern.[10] Call this the *health view*.

We are inclined to accept the health view. While we cannot claim to provide a full argument for this position we offer an example to support it. If we have a fixed amount of money at our disposal to spend on any initiative, should we let the health view or the healthcare view guide us? If it is healthcare that is our focus, we would opt for measures that increase access to healthcare. Guiding us to give priority to preventive health visits in vulnerable areas or mandatory health checkups initially seems to speak favorably for the healthcare view. But assuming the availability of another policy that left the access to healthcare as it is, but provides a larger increase in health for the group in question, this conclusion seems less obvious. If initiatives such as providing apples in schools, cleaner air or better sewage systems would result in a larger increase in health, how are we to choose between such initiatives and those who increase the access to healthcare? On the healthcare view we don't have much choice, since only the first group of initiatives affects access to healthcare. On the health view we can prefer whichever gives the greatest health benefit for the group in question. We believe this to be the most plausible scale to evaluate alternate initiatives. The initial appeal of the healthcare view might be derived from its perceived positive effect on people's health. When alternatives not related to healthcare do better in providing health benefits, it becomes apparent that health as such should be our concern.

Integration. Luck egalitarians can differ in how they perceive the relationship between the concerns of justice in health and healthcare and other concerns of justice. The question here is whether we are proposing a theory dealing specifically with health alone, or one considering it in relation to other concerns of justice as well. Borrowing a terminology used by Caney on another topic, we could refer to the former approach as the *isolationist view,*

while calling the latter the *integrationist view.*[34] The former seems prominent in medical ethics, where the relationship to other spheres is often opaque or unaddressed.[35–37] This means that the literature often addresses health as a separate issue, rather than as an issue interconnected with other issues of justice. One instance where this would make a difference is in relation to an unchosen health disadvantage which we cannot remove. An isolationist theory of health would say that this unfortunate state of affairs cannot be remedied. The integrationist view, on the other hand, could recommend addressing the shortfall in advantage located in the sphere of health by compensating the person in some other way not associated with health. Increased public spending targeted to individuals of this sort would be one way of doing this. For instance, if we found that members of the working class had systematic health disadvantages, only some of which could be removed in a reasonable timescale, we could respond by providing improved public education for this group.

While some may find this an attractive suggestion, we imagine that not all will. The integrationist view is, however, supported by two further considerations. The first is that isolationist approaches risk imposing burdens on people who experience unchosen disadvantages in every sphere of life except health, thus increasing rather than decreasing the extent to which their lives as a whole reflect unchosen circumstances. Suppose A has little money, an unsatisfying job, and an overall below-average standard of life, while B is rich, loves his work, and generally has a wonderful life. If A's health is but a little better than B's, the isolationist view would recommend prioritizing improvements to B's health. This will work to reduce or eliminate the one advantage A has over B, and expand the inequality in their overall life prospects. This would seem at odds with luck egalitarianism in general. Integrationism, by contrast, can take into account these wider considerations. As a further suggestion of the viability of the integrationist view, consider another example, where we have to choose between different policies. Initiatives y and z would have equal effects on people's health, but z also decreases unchosen economic inequality. An isolationist theory cannot prefer one over the other, while an integrationist view would be readily equipped to prefer the initiative which best satisfies other concerns of justice. The choice we make in whether to develop an integrationist or isolationist theory thus has important implications for the policies such a theory would recommend and which inequalities it would address.

Plurality. It seems very likely that there is a plurality of relevant values. Almost all luck egalitarians recognize that luck egalitarianism must be complemented by principles reflecting other values.[1,4,10,38] There are, in our view, compelling reasons for doing this, one of which is the leveling down objection to egalitarianism.[5] It points out that, that while luck egalitarianism tells us to correct any unchosen inequalities between C and D, it does not by itself tell us that we should prefer to do so by increasing C's advantage level rather than by decreasing D's advantage level.[10]

Given that most luck egalitarians endorse a *pluralist view* rather than a *monist view*, and have good reasons for doing so, the most interesting question in this area is which other values should be taken into account. One form of pluralism would be to cite values to be balanced against the assessments made by luck egalitarianism. Within a healthcare context, candidate values include respect for autonomy, nonmaleficence, beneficence and utility.[35] A different approach would be to introduce another distributive value instead of (or as a supplement to) egalitarianism. This value could be prioritarian, giving more weight to people's interests the lower their absolute level of health or healthcare,[10,39] or

sufficientarian, keeping people above a certain threshold of advantage.[40] Combining luck egalitarianism with prioritarianism supplements the concern with whether people's relative share reflects unchosen circumstances with a concern for their absolute level of advantage. Combining luck egalitarianism with sufficientarianism supplements the concern with whether people's relative share reflects unchosen circumstances with a concern for keeping people above the specified threshold.

Objections

Luck egalitarianism has been met by important objections. Since some of the most powerful objections draw their strength from pointing towards its application in relation to health and healthcare it might be said that such an application is a hard case for luck egalitarianism. In light of the framework developed above, we discuss three prominent critiques.

Respect. One powerful objection has been proposed by Wolff. He argues that the process of collecting the data needed for luck egalitarian institutions to function and for implementing choice-sensitive policies will fail at the important egalitarian task of showing equal respect towards all people.[41] According to Wolff it is possible that luck egalitarian institutions will fail to show common courtesy, show distrust towards its potential claimants or require shameful revelations from the people under assessment. While it is hard to think of a lack of common courtesy as an integral part of any policy, it seems to be the case for the application of luck egalitarianism in health that some policies will require the gathering of information about past behaviors and circumstances so that we cannot design a luck egalitarian policy without one or more of the features Wolff describes.

On reflection luck egalitarians would have (at least) two distinct ways of dealing with this critique. It is reasonable to expect that treating any individual in the fashion described by Wolff would result in a loss of welfare. Such welfare losses could and should be a concern for a welfarist luck egalitarian and can potentially outweigh the other luck egalitarian reasons that support the introduction of an overtly choice-sensitive policy.[42] For instance, if we accept that many obese people are responsible for their obesity and consequent health problems, we have a luck egalitarian reason for wanting to identify these people so we can pass costs on to them. But it may be that the investigations needed to distinguish these people from other obese people who are *not* responsible for their condition would be so demeaning and consequently costly in welfare terms for the latter group that such a policy would increase unchosen inequality. A second luck egalitarian response is that even if we could allocate costs to the first group of obese people (those responsible for their condition) without imposing costs on the second (non-responsible) group, we should not do so on pluralist grounds. For instance, many of the obese might be badly off in absolute terms and so be of particular concern for prioritarianism, or be in danger of falling below the sufficientarian threshold. As we have seen pluralistic luck egalitarianism can respond to concerns such as these. For these reasons, luck egalitarian goals might better be served by a seemingly choice-insensitive policy, which does not allocate any special costs to any of the obese. In other words, this choice-sensitive theory of egalitarian justice may be best served by a choice-insensitive rule of regulation.[43]

Harshness. This objection concerns how luck egalitarianism treats those who end up worse off as a consequence of their own choices.[44,45] Fleurbaey offered the colorful example of

the uninsured motorcyclist, who is badly injured while carelessly riding without a helmet and left to his fate by luck egalitarianism.[45] This kind of case is important since it is routinely put forward in order to criticize the application of luck egalitarianism in health,[22,26] and is also acknowledged as a significant obstacle among those more drawn to luck egalitarianism.[10,46]

One possible response would be to argue that cases of luck egalitarian harshness are too rare in a real world context to suffice for the rejection of luck egalitarianism.[47] But though such a practical argument might have some plausibility it leaves the theoretical relevance of the harshness critique untouched.[48] When a pluralistic approach is introduced, however, it is clear that we can deal with the critique in several ways. For instance, prioritarianism allows us to have special concern for people with very low levels of advantage, even where they are responsible for their condition, while sufficientarianism would allow us to care for them if they fall under a specified threshold. In a similar fashion an adherent to the value of beneficence, which holds that there is an obligation to benefit others, would allow us to care for people such as the motorcyclist.

Promotion. Norman Daniels has voiced the objection against luck egalitarianism that its concern for whether distributions reflect people's choices makes it unfit as an approach to health. The reason for this is that this concern for responsibility surpasses a concern for health promotion in a seemingly implausible way. To see why this might be so consider a case where institutions are in place that make sure that only unchosen inequalities (however construed) are eliminated, while chosen ones are left untouched. In such a situation why would luck egalitarians prefer that people made healthy choices rather than unhealthy? [20] The point made by Daniels is essentially that luck egalitarians can prefer that a distribution reflect people's choices, but cannot prefer that some choices rather than others occur, provided institutional measures ensure that others are not asked to bear the cost of these choices. This critique is specifically relevant in the context of health, since it claims that luck egalitarianism is unable to support initiatives to promote healthy lifestyles and thus, that many aspects of health promotion seem unattainable for luck egalitarianism.

Pluralism again seems to be an important part of a possible luck egalitarian answer here. For instance, if we are prioritarians, we will have direct reasons for wanting to make sure that people, and especially the worst off, achieve good health outcomes. This is the case because the prioritarian concern allows us to care even for those, who are responsible for their plight. We would therefore have grounds for favouring the promotion of healthy lifestyle choices.

Applications

In the foregoing sections we have set out an approach to luck egalitarianism in the area of health and healthcare, and defended it against some common objections. In this final section we consider how this approach bears on several important real world issues of public health and healthcare allocation.

Scarcity. Many distributive decisions involve some form of scarcity. It is therefore crucial to determine, whether scarcity changes our evaluation of a distribution. One view could be that scarcity makes considerations other than need, such as responsibility, irrelevant.[49]

However, an alternative view suggests that when scarcity forces tough choices upon us, we must see first to those who are least responsible for their current disadvantage.

Luck egalitarianism comes down firmly on the side of the second view. On this view, there is nothing about scarcity that would make it appropriate to disregard responsibility considerations. And on further consideration, why should the presence of scarcity have a bearing on which fundamental moral considerations should come into play? Many decisions are affected by scarcity and it seems odd to suggest that we should, in situations where we have the least amount of resources and are least able to bring about more, invoke principles less attentive to whether people have some responsibility for their need for resources. Luck egalitarianism therefore suggests that those who are responsible for their need for a scarce resource should, all else being equal, receive lower priority than those who are not in this way responsible.

However, it should be emphasized that luck egalitarianism is a view about how to *respond* to responsibility, not a view about who is in fact responsible for bringing about what. Consider, for example, the seemingly responsibility-sensitive policy of giving lower priority to people whose need for a new liver is related to alcohol consumption. While luck egalitarianism under certain empirical conditions and on a specific theory of responsibility is compatible with such a policy, it is not an integral part of luck egalitarianism to claim that this group of patients is in fact responsible for their condition. We again find that luck egalitarianism does not provide the unmitigated support for real world attempts at 'choice-sensitive' policies that many suppose it to.

Financing. Another issue is who should pay for the healthcare system and health promoting policies. This is important since healthcare expenditures claim a large share of the national budget in developed countries. In the EU, for example, member states spend on average 9% of GDP on health and healthcare, while the US spends twice this amount.[50,51] If we believe that people should contribute to healthcare expenditures in accordance with their health-related choices, as luck egalitarianism seems (with some provisos) to suggest, several options are available.

One approach would be to make those deemed responsible for their own bad health contribute through out-of-pocket payments to the costs associated with their treatment. Such a scheme however does risk that many people will be unable to pay the considerable costs. An alternative would be to tax activities or consumer products likely to result in bad health.[7] A related option is insurance schemes where the insurance premium reflects people's behavior, with some proposing a scheme of mandatory insurance.[52,53] Both the tax and mandatory insurance options do, however, involve placing unavoidable costs on people whose risky behavior in the end does not result in bad health, a controversial outcome in the luck egalitarian literature.[54,55]

The last possibility to be mentioned is a financing scheme, where healthcare and health policies are financed through general taxation. At first this might seem a bit at odds with the luck egalitarian perspective of this article, since it makes no straightforward attempt to place the burden of finance upon those who take risks with their health or end up creating expenses in the healthcare system. An isolationist view would tend to favor such a dismissive verdict. But from an integrationist perspective, it might be considered. If health is an element we care about along with other things, then in a society with significant unchosen inequalities in wealth, we should worry if a responsibility-sensitive financing of healthcare would increase such inequalities, while a general taxation scheme that places the

heaviest burden on the rich might all things considered be the solution which most reduced the degree to which the distribution reflected unchosen circumstances. This means that luck egalitarianism on our view does not necessarily come down in favor of a system where out-of-pocket payments, insurance schemes or other mechanisms make sure that the ill pay for their own treatment to a significant extent. When we know that the burden of disease is borne disproportionally by the poor[56], we may have luck egalitarian reasons to prefer a system more similar to that of Canada or Western Europe, where general taxation on the rich benefits the poor through improved public health care provision.

Consequences. Even if we assume luck egalitarianism *and* some degree of responsibility for bad health it is not in itself obvious which practical consequences should follow from that responsibility. This follows partly from the wide range of measures we could employ towards such an end. We could vary the quality of care people receive, the price they pay for their treatment, or their place in a queue for scarce resources (and any combination of such measures).

The evaluation of these measures depends on a number of considerations. These might include the expected benefit of treatment, the cost of treatment in relation to the patient's wealth, and the extent to which the person is responsible for his condition. For instance, increasing a patients' proportion of treatment costs may seem more appealing the less urgent the treatment, the lower the cost of the treatment, the richer the patient, and the more responsible the patient is for the medical need. It should also be taken into account which other responsibility-tracking measures are already in place. It would matter, presumably, whether people's behavior has already had some kind of consequence through specific taxes, higher insurance premiums, or similar.

Taking these points together, it may be that, in countries with high levels of tax on tobacco and in which smokers are disproportionately poor, smokers who develop lung cancer should usually be relieved of paying the financial costs of their treatment because they have already paid significant costs via taxes, often have little capacity for paying more, and may be considered to have less than full responsibility for their smoking for socioeconomic reasons. By contrast, if the victims of skiing accidents have not paid high taxes on their risky behavior and are typically wealthy, it may be reasonable to expect a patient contribution. The specific consequences which follow from risky behavior depend on several factors and are unlikely to be uniform across different categories of disease and injury.

Conclusion

Above we tried to present what we consider a viable framework for luck egalitarianism in health. The purpose has been to bring forth distinctions and concepts which we believe can advance the debate about luck egalitarianism in this context. The purpose of this article has for the most part been an exploration of concepts, rather than an attempt to argue for our own convictions. On three central themes we have, however, argued for our own view. Luck egalitarians should address distributions of health rather than healthcare, endorse an integrationist theory that combines health concerns with general distributive concerns, and be pluralist in their approach.We also discussed what we consider to be some of the most important objections against such an application of luck egalitarianism. Finally we addressed real world topics such as medical scarcity, health financing schemes, and institutional approaches to introducing personal responsibility to health policies. A further point that

arises from the discussion is that one should be careful not to leap too quickly from a choice-sensitive theory of egalitarian justice to a choice-sensitive rule of regulation. We have seen that there may sometimes be good luck egalitarian reasons for pursuing choice-insensitive policies.

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