On Engster's Care-Justification of the Specialness Thesis about Health Care

ABSTRACT:
To say health is 'special' is to say that it has a moral significance that differentiates it from other goods (cars, say, or radios) and, as a matter of justice, warrants distributing it separately. In this essay, I critique a new justification for the specialness thesis about health care (STHC) recently put forth by Daniel Engster. I argue that, regrettably, Engster's justification of STHC ultimately fails and fails on much the same grounds as have previous justifications of STHC. However, I also argue that Engster's argument still adds something valuable to the debate around STHC insofar as it reminds us that the moral significance of health care may be wider than simply its effect on the incidence of disability and disease: one further reason we may think health care is morally significant is because it concerns the treatment and care of those who are already unwell.

INTRODUCTION

To say health is 'special' is to say that it has a moral significance that differentiates it from other goods and, as a matter of justice, warrants distributing it separately.[1] (By health care here it is usually meant all those treatments and services typically covered by a comprehensive public health service: i.e. primary, secondary and tertiary care as well as some public health measures).[2]

Although few policy documents refer explicitly to this idea, one might see it as underpinning much of the way we approach matters of health policy, particularly around funding. Why fund health care through public taxation? We do not do this to ensure that everyone has equal access to a car, or a television. Why not have a system wherein people's access to health care is dependent upon their ability to pay, with each individual

purchasing whatever health care goods they are able on the open market? Well, one of the things we might say in response to these questions is that there is something different about health care, that health care services have a moral significance that differentiates them from other goods and which, as a matter of justice, demands that we distribute them differently, perhaps in a more egalitarian fashion.

In light of the apparent prevalence of the specialness thesis about health care (or STHC), it is perhaps surprising that in recent years it has come to be treated with a degree of scepticism within the philosophical community. For some, of course, STHC has never been justifiable.[3 - 9] More damningly, though, even some of STHC's one-time advocates, such as Norman Daniels,[10-12] have now largely abandoned it, favouring instead the wider claim that all goods that meet health needs are special, rather than just health care.[2, 13-15]

If right, this finding could have significant ramifications for the way we fund health systems. For if something like STHC is the reason why we tend to distribute health care independently of ability to pay, then proof that we have no good reason for thinking STHC is true would likewise suggest that we have little *moral* justification for distributing health care differently from other goods. (Although, perhaps, there might be certain non-moral justifications). After all, assuming we think it is morally acceptable to distribute *some* goods according to ability to pay, and we have no reason to think health care is any different from any other sort of social good, why not distribute it through the market as well?

Some philosophers may demur at this point, arguing that the current consensus is not that health care is *not* special, it is just that there are a lot of other goods that are *also*

special – including housing, sanitation, education and so on – with health care still one of that bundle, being one good that helps us meet health needs. However, even accepting this line of reasoning, we are still forced to conclude that health care is, at most, one of a bundle of special goods and potentially not even a particularly prominent member of that bundle. Whichever way one cuts it, then, findings from the philosophical literature seem to suggest that health care is a lot less special than we thought it was and allocation according to ability to pay may be far less of an injustice.

In an attempt to turn back this tide of philosophical opinion, Daniel Engster has recently put forth a new defence of STHC, one which he takes to justify the claim that health care is special where other theories have failed.[16] The main novelty of Engster's thesis, as he explains, lies in the fact that, on his account, health care's specialness is less a product of its role 'in promoting *health*' as in 'providing individuals with everyday medical *care*'.[16] For Engster then, appreciation of the moral significance of health care's 'caring dimensions' can account for health care's specialness in a way its 'health dimensions' (perhaps) cannot.[16]

In this article, I argue that, regrettably, Engster's justification of STHC ultimately fails and fails on much the same grounds as have previous justifications of STHC. Despite this failure, though, I think Engster's account does have something valuable to add to the debate around STHC. In directing our attention toward health care's 'care dimensions', Engster's thesis reminds us that health care's moral significance may be wider than simply its effect on the incidence of disability and disease.

The article proceeds as follows. In Section One I foreground Engster's thesis by setting out a traditional account of claims made by STHC. Here I draw mainly on an

authoritative and minimalist account of STHC by Segall. In Section Two, I then review Engster's new care-justification of STHC. In Section Three, I explain why I think his argument fails before going on to highlight what I think Engster's contribution adds to our discussion around STHC in Section Four. I conclude in Section Five.

1. THE SPECIALNESS THESIS ABOUT HEALTH CARE

What might it mean to say that health care is 'special'? In recent years, conceptions of this thesis have tended to coalesce around the kind of claim set out at the start of this essay, one originally articulated by Shlomi Segall.[1] On Segall's account, to say health care is special is to say that it is 'morally important in ways that justify distributing medical resources *in isolation* from the way in which other social goods…are distributed'.[1] Following Michael Walzer's account of what it means to distribute one good in isolation from another,[17] Segall argues that STHC is most usefully exercised when it is understood as the claim that, given health care's moral significance, the fact that person possesses Y ought not determine how much health care they are allocated.

As well as being one of the more popular accounts of STHC in the literature, there are a couple of reasons why this account of STHC in particular provides a good basis for our current discussion. First, Segall's definition is *parsimonious* in that it offers a formulation of STHC divorced from a number of extraneous claims, sometimes talked about in conjunction with STHC (including by Segall) but which can add an extra explanatory burden on justifications of that thesis. Three such claims are worth noting: i) that health care is *uniquely special*; ii) that it is the *most important* or *chief good*;[18] and

iii) that the pattern of distribution demanded by health care's specialness is an *egalitarian* one.[19,10] None of these claims are explicitly ruled out by Segall's definition of STHC and thus admit to combination. We might, for example, define the specialness thesis as the idea that health care is morally important in ways that justify distributing medical resources in isolation from other social goods *and* that it is the most important or chief good. At the same time, however, nothing about STHC demands we include these claims either. In order to ensure, then, that we test Engster's care-justification of STHC against the barest possible definition of STHC – one which correspondingly admits the widest possible range of justificatory theories – Segall's account is the best candidate available. By Segall's definition, it would be of no embarrassment to Engster if his thesis did not also justify, say, health care's status as the chief good. Rather his theory only needs to show that it ought to be distributed differently from other goods.

A second virtue of Segall's account, one that directly follows from its parsimony, is its *inclusivity*. That is, one way we might think of Segall's formulation is as an attempt to describe what a number of authors have meant when they talk about the idea that health care is special. In adopting Segall's description of STHC then, we ensure that our assessment of Engster's care-justification is situated squarely within the existing literature around health's specialness and that it is being held to the same standards as are other accounts.

To sum up then, on the account of STHC I shall be using in this article to say that health care is 'special' is to say that, as a matter of justice, it is morally important in ways that justify distributing medical resources in isolation from the way other social goods are distributed, (with 'distributing X in isolation' meaning that the fact that person possesses

Y ought not determine how much of X they are allocated). Moreover, as I understand it, in making this claim, STHC does not also claim that health care is uniquely special, nor the most important or chief good, nor does it claim that health care's moral significance demands its distribution in any particular pattern (egalitarian or otherwise). What it does say, however, is that insofar as any health care treatments or services are allocated simply according to, say, P's level of wealth or ability to pay – that is, according to the market – such processes of distribution are necessarily unjust.

2. ENGSTER'S CARE-JUSTIFICATION OF SHTC

How, then, does Engster go about justifying STHC? Engster's principal thought here is that that '*care*…the other half of *health care*…provides the best reason for states to continue subsidizing comprehensive health services'.[16] In advancing this thesis, Engster takes his theory to be sharply distinguished from all those theories that have sought to justify STHC on the basis of health care's 'health dimensions' – most notably Daniels's opportunity-justification of STHC.[10-12] To make this explicit, Engster draws what he takes to be a strong distinction between health care's care-directed services and its health-directed services. Thus, where the 'health dimensions' of health care cover 'curative measures that medical professionals take to save people's lives or restore them to good health', the 'caring dimensions' of health care *also* cover 'all the other activities they regularly engage in to help individuals function as well as possible and avoid or minimize their pain and suffering – even when good health is not a realistic goal'.[16] In contrast to Daniels' theory, then, care ethics emphasises 'the value of everyday medical

care', that impacts 'on their everyday functioning and sense of well-being', even though such minor illnesses and injuries may have 'little or no effect' on individuals' opportunity range.[16]

Having made this distinction, Engster then goes on to argue that, unlike health care's health dimensions, the moral significance of health care's caring dimensions is accounted for first and foremost by the moral significance of care, with this, in turn, being accounted for in various ways. First, we might see the giving of care as demanded by a principle of reciprocity: 'We all have a moral responsibility to care for others in need, as well as to support public policies that support the care of others because we all depend or have depended on the care of others in our own survival and functioning'.[16] Second, the care aspects of medical care can be considered morally important 'for the contribution it makes to the quality of people's lives'.[16] Third, caring for others in need can be seen as a matter of easy rescue ('we have a moral duty to relieve the suffering and facilitate the functioning of individuals when we can do so at relatively little cost to ourselves'),[16] which in turn can be seen as a form of reciprocity ('we would want such care for ourselves in similar circumstances')[16] and beneficence (we 'can recognise the moral force of helping them').[16] Understood thus, Engster takes the moral significance of health care's caring aspects to justify both the 'specialness' we accord to health care and the distribution of a comprehensive set of health care services through public subsidy across 'at least a large portion of the population'.[16]

As well as presenting an entirely new justification of STHC, one significant benefit of this account, according to Engster, is that it justifies STHC in such a way that avoids one pressing objection to existing, health-based justifications of STHC: the social

determinants of health objection. Given the importance of this latter argument in much of what follows, it is worth spending a brief moment looking at it here.

What has now become known as the 'social determinants of health objection' was originally devised as a counter-argument to a defence of STHC set out by Norman Daniels in the early 1980s. When Daniels originally defended STHC (as noted earlier, he has since changed his position somewhat), he did so by starting from what he then took to be a relatively uncontroversial observation: namely that one thing that differentiates health care services from other kinds of social goods is the contribution they make to our health. It was this feature of health care goods, Daniels argued, that ultimately grounded STHC. Given the 'strategic importance' of *health* to our 'normal opportunity range', (that is, the range of opportunities open to us, given our particular society and particular talents), the specialness of *health care* can be seen to be generated by any theory defending a principle of fair equality of opportunity, health care goods being morally different from other goods in their 'strategic' effect on the range of opportunities we can normally pursue.[10]

Now, almost as soon as it was published, this argument was criticised on a number of counts. However, it seems fair to say that Daniels's thesis did not face a challenge he did not think it could meet until, over the course of the 1990s, many of the empirical claims upon which his thesis rested came under increasing pressure from new research in social epidemiology into health's 'social determinants'. Famously, this research found that while health care did have a significant effect on the incidence of disease and disability, at least as significant, indeed perhaps even more significant, were the social determinants of health, i.e. our social and psychological environment,

environment in early childhood, working environment, unemployment and job insecurity, friendship and social cohesion, social exclusion, effects of alcohol and other drugs, access to healthy food, and so on.[20] Of course, these findings did not falsify Daniels's claim that health care has a strategic effect on one's normal opportunity range. However, as Daniels was quick to realise, it did call into question health care's relative significance in this regard. Put briefly, if the matter at hand was which goods were best placed to lower the incidence of disease and disability (as it was for Daniels), then a whole host of other goods and services should be considered special before health care, diluting health care's distinctiveness, importance and, ultimately, its specialness as a result. [1, 6, 21]

For Engster, then, one of the benefits of his thesis is that it is able to avoid this objection to STHC. As he explains, here it might be wondered 'why the social determinants of health literature does not undermine care-based justification for public health care just as it did for the health-based justification…why not invest in the social determinants of health rather than health care?'.[16] In response, Engster argues that even under 'ideal social and environmental conditions' – i.e. even when all social determinants of health had been fulfilled – 'comprehensive health-care services would still be necessarily to help people cope with injury, disease and deterioration'.[16] Hence, while 'it makes sense to focus on the social and environmental determinants of health' when 'the goal is to reduce early mortality and promote good health', when it comes to 'mitigating the effects of the illnesses, injuries, and bodily and mental decay that are unavoidable parts of human life', 'medical care…will always be important'.[16]

3. TWO PROBLEMS WITH ENGSTER'S ACCOUNT

For reasons I will go on to discuss in Section Four, I think Engster's care-justification of STHC does have something important to say about health care's moral significance, maybe even its specialness. However, to my mind, if we are to follow Engster's theory to the letter we must also conclude that it cannot justify STHC.

First, despite his claims to the contrary, Engster's account looks like it is still susceptible to the social determinants of health objection. On this point, Engster does not always help himself, for his own response to this objection fails to recognise the main point of the argument. As set out above, Engster seems to think that his justification of STHC resists the social determinants of health objection because it shows that even in a world where policy makers had done everything possible to address health's social determinants, a public health services would still be necessary. However, as is clear from the discussion above, the evidence on health's social determinants did not undermine the specialness of health care because it suggested health care is no longer *necessary*. Rather, as Daniels notes, it undermined STHC because it revealed that health care was not the *only* good that might help resolve the problems to which health care was directed.[1,22] Hence, insofar as Engster proves that a comprehensive health care service would still be necessary in a world where all the social determinants of health had been addressed, his argument answers a question that no-one had really asked.

The real question raised by the social determinants of health objection, when applied to Engster's thesis, is this: given what we now know about health's social determinants, is there is any reason to think that more could be done to meet *what Engster describes* as health care's 'care dimensions' through action on health's social

determinants than through the provision of health care? Regrettably, though, in respect to *this* question, Engster's thesis looks fallible. The basic problem here is that because Engster takes health care's 'caring dimensions' to be addressing effectively the same problems as health care's 'health dimensions', there seems good reason to think that, again, we could do a better job of responding to those problems through action on health's social determinants than the provision of a comprehensive health service.

There is, perhaps, a degree of ambiguity here, for Engster is not always entirely clear about exactly how health care's 'care dimensions' do differ from its 'health dimensions'. At some points it can look like Engster wants to argue that this distinction is really about the 'severity' of the problem the given service is intended to alleviate. On this view, then, while health care's health-directed activities cover treatments for 'major' disabilities and diseases, its care-directed activities cover treatments for 'minor' ailments. Elsewhere, though, Engster seems to argue that the distinction between health-directed health care and care-directed health care is a matter of how far a given treatment is intended to bring its recipient back to a state of good health. Thus, where the 'health dimensions of health care' cover *restorative* activities (those that aim 'to save people's lives or restore them to good health'),[16] the 'caring dimensions of health care' cover *lenitive* activities (those that, more modestly, aim to 'help individuals function as well as possible and avoid or minimize their pain and suffering',[16] or, in other words, to take them some of the way to full-functioning, ensure they plateau at some point below full functioning or slow down their rate of deterioration).

It looks like there might be problems with both these distinctions. For example, the restorative/lenitive distinction seems to face an aggregation problem: when does the

administration of several lenitive treatments in conjunction add up to what is, in effect, a restorative treatment? Regardless of these issues though, and whichever of the two distinctions Engster ultimately wants to use, it still looks like, for Engster, both health care's health-directed activities and its care-directed activities are broadly intended to address the same set of problems: which is to say, people suffering from disabilities or falling ill. This being so, we might *still* think we can do more to ensure individuals do not suffer from such problems through action on health's social determinants than we could by providing health care. Engster's care-justification for STHC therefore falls foul of the social determinants of health objection in precisely the same way Daniels's did before it.

How might Engster respond to this objection? One path he might take here, perhaps, is to follow Daniels's more recent arguments and to claim that even if his theory fails to establish STHC, it does succeed in justifying a specialness thesis about *all those goods that meet care needs* – which is to say, any good that is able to help with 'minor' ailments, or those problems that can only be alleviated rather than cured.

Now, there are, I think, good reasons to doubt these sorts of positions are sustainable (see, for example, Wilson's worries about Daniels's specialness thesis about all those goods that meet health needs).[23] However, even assuming that such positions are attractive, Engster's account actually fares far worse than Daniels's. This is because another problem with Engster's account is that it fails to show how the particular kind of moral significance we attach to health care's 'care-directed activities' is any different from the moral significance we attach to any other sort of good.

Again, there is a degree of ambiguity here, for, as described in the previous section, Engster claims that the moral significance of health care's care dimensions can

be accounted for in a number of ways. However, one point he stresses is that the reason medical care's care activities are morally important is by virtue of the 'contribution' they make 'to the quality of people's lives'; a point which he appears to pick up in much of his talk around the importance of relieving pain and suffering.[16] Yet, if *this* is what makes the care dimensions of health care morally special, then Engster's argument seems susceptible to the same counter-argument that various authors have made against other, more utilitarian defences of STHC: namely, that it becomes difficult to see why health care is any different from any other social good in this respect.[11, 24, 25] After all, if health care's moral significance lies in its ability to relieve pain and suffering (to make a difference to our 'quality of life'), why should we think it is any different from a good holiday, or a day at the cricket? Engster's account of the moral significance of health care's 'care dimensions', then, appears to violate a key desideratum of any theory attempting to justify STHC: namely, it does not provide a coherent account of how, by virtue of its particular kind of moral significance, health care differs from at least most other sorts of goods.

4. WHAT ENGSTER GETS RIGHT

Following the arguments above, then, there seems good reason to doubt that Engster's thesis can justify either the specialness thesis about health care or even some sort of specialness thesis about 'goods meeting care needs'. However, despite these shortcomings, I think Engster's argument still adds something valuable to the debate around STHC. Most notably, in directing our attention to 'care…the other half of health

care',[16] Engster reminds us that the moral significance of health care may be wider than simply its effect on the incidence of disability and disease. Rather, one further reason we may think health care is morally significant is because it concerns the treatment and care of those who are already unwell. In this, I think Engster actually hits on a characteristic of health care that does differentiate it from other goods, even those goods through which we might affect the social determinants of health. For although action on say, our social and psychological environment, or environment in early childhood, may help reduce the *chances* we get ill, or suffer a disability, none of these measures will have any effect on us once we actually do fall ill, or suffer a disability. To remedy *that*, we need health care.

It is this kind of thought, I think, that seems to motivate much of Engster's discussion about the 'caring' side of health care. Now, unfortunately, as we have seen, Engster's theory ultimately fails to build on this idea in a way that would allow him to justify STHC, (most notably because he ends up describing the 'caring' side of health care as so close to its 'health' side that it renders the thesis open to the social determinants of health objection). However, looking past the particulars of Engster's theory for a moment, we might still think that if the specialness of health care (and health care alone) *is* to be established, then one promising line of enquiry would be to consider its importance with respect to the treatment of those already unwell.

5. CONCLUSION

In this article, I have reviewed a new justification for the specialness thesis about health care recently put forth by Daniel Engster. I have argued that, regrettably, Engster's thesis ultimately fails to justify STHC. However, I have also argued that there is much of value in his work. Most notably, one of the things Engster's focus on care does is to direct our attention to a facet of health care's moral significance often neglected in the secondary literature: that is, the extent to which it concerns the treatment of those already unwell. If STHC is to be established, and the public provision of health care to be defended morally, there seems good reason to think it may well be by starting from this initial thought.

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