

WHAT IS THE POINT OF HEALTH CARE? A DEFENSE OF RELATIONAL APPROACHES TO JUSTICE
IN HEALTH CARE

By

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To Susan, Virginia, Ruvimbo, Joy, and Milani

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INTRODUCTION

Background: The Serena Problem

On September 1, 2017, tennis superstar Serena Williams gave birth to a healthy child. On September 2, 2017, she began to have trouble breathing. Having had a pulmonary embolism that nearly killed her six years prior, Williams immediately notified her attending medical staff that she was likely having another embolism and asked for a scan of her lungs and blood-thinning medicine. What followed was a series of experiences that many women, especially Black women, have had. Serena's pleas were minimized and dismissed. A nurse suggested that Williams might be confused, and a doctor examined her legs instead of her chest and determined that there was nothing to worry about. For many Black women, encounters with medical staff in similar circumstances often result in adverse health outcomes (Haskell 2018; Salam 2018).

Fortunately for Williams, the necessary scan was eventually performed, revealing blood clots in her lungs in enough time for the doctors to administer the appropriate treatment. Nonetheless, what strikes me about the Williams case is that despite being a highly privileged and successful woman with access to the kinds of resources and care enviable to most, Williams' ordeal reveals her status as a member of the demographic group with the worst pregnancy-related outcomes in the United States of America (US).¹ Williams experienced what it is like to be a Black woman in US health care when Black women have some of the worst statistical health outcomes in the US of any racial, ethnic, or gender group. The numbers are startling. Black women have the highest pregnancy-related morbidity and mortality rates of any racial or ethnic group in the US. They are three to four times as likely as white women to experience adverse pregnancy-related outcomes. Furthermore, unlike global trends, pregnancy-related morbidity and mortality rates in the US have not only increased but have more than doubled since the late 1980s, particularly affecting Black women (Marmot and Wilkinson 1999, 319; Creanga et al. 2017).

Poverty is sometimes taken to explain these racial health disparities. However, as the Williams example suggests, these adverse disparities persist even when economic factors are neutralized. For example, data has shown that Black women in the highest socioeconomic stratum have worse pregnancy-related health outcomes than White women in the lowest socio-economic stratum (Marmot and Wilkinson 1999, 239). These data are surprising given the generally positive correlation between socio-economic status and health outcomes. However,

¹ See, for instance, the US CDC (2017) which reports morbidity and mortality rates for non-Hispanic Black women in several disease categories that are disproportionately the highest in those categories.

I believe that these outcomes are unjust due to the disproportionate rate at which they happen and how they contribute to the history of harmful encounters with the health-care system experienced by Black women in the US.

Although not directly my focus, these cases and related empirical findings, along with the intuition that they are evidence of injustice, have led to the primary question that motivates this dissertation. That question, broadly construed, explores what it takes for the state, primarily in the form of a federal government, to make a health-care system just in a way that can register the moral harm done to individuals and health groups. The Williams case motivates this exploration because of how it suggests the various registers of moral harms. This case complicates standard distributive approaches to justice. For instance, if justice is measured by the distribution of some material or non-material goods as some theories of justice posit, then it is unclear what sort of distribution would ameliorate the injustice suffered by Williams if her social and material resources provide her with all relevant distributive privileges.

This problem is what I refer to as "The Serena Problem." The Serena Problem is: *There are instances of unjust health disparities that persist despite any distributive correctives aimed at resolving them.* Additionally, even if we grant that the pregnancy-related health outcomes of Black women are unjust, it is unclear whether the socio-economic status of Black women like Williams problematizes the claims to justice of Black women as a health group. It is also unclear whether someone like Williams can have her justice-relevant concerns addressed if she, as an individual, is not included within the conception of the individuals taken to be the targets of distributive interventions aimed at eliminating racial health disparities. These aspects of the Serena Problem suggest two broader challenges in thinking about justice in health care. The first challenge is about how we ought to think about groups as relevant units of concern, and the second challenge is about how we can capture all individuals who might be subject to injustice.

My focus in this dissertation is on groups and overlooked individuals. Much of the literature I engage with bases the pursuit of justice in health care on a narrow conception of autonomy that posits atomistic individuals as the primary units of moral concern. Instead, I am interested in exploring the pursuit of justice in health care when groups are taken to be legitimate units of moral concern and individuals are taken to be fully and constantly socially situated. This interest is motivated by the observation that injustice can and does affect groups and persons who are interconnected. While in the throes of thinking about and writing this dissertation, this observation has been reinforced by the two-pronged crises of the COVID-19 pandemic and the social unrest linked

to the murders of Ahmad Arbery, Brianna Taylor, George Floyd, and others. These events were crises for individuals, yes, but they have also been public health crises for those individuals qua members of social groups. Not all injustices take this valence, but certainly, some do. Nevertheless, I find the discussion of this feature of injustice largely muted in large pockets of theories of justice in health care. In this dissertation, I attempt to unmute this conversation and think critically about what this claim means for the pursuit of justice in health care.

Objectives and Framework:

These problems point to two narrower organizing questions that I explore in this dissertation. The first question is whether justice in health care is best conceptualized as a matter of individual holdings or, at least in part, a matter of social relations between citizens. The second question explores the circumstances in which injustice in health care occurs at the level of groups in the form of health populations. In exploring these questions, I aim to show that in the non-clinical domains of health care that are not primarily concerned with treating individuals, injustice can be both relational and group based. By group-based, I mean to pick out both the way that some harms happen in virtue of one's group membership and the way some harms are only legible at the group-level. I will try to show that group-based injustice can happen in either or both senses. If injustice can be group-based in this sense, then the pursuit of justice in non-clinical health care must be relational. A relational pursuit of justice allows liberal egalitarians to provide interventions that properly address the social nature of group-based injustice.

I focus my attention on public health as an example of a non-clinical domain of a modern health care system. This focus allows me to provide a clear and focused exploration of health's social dimensions. Nonetheless, I believe that this exploration has implications for other health-care sectors that can be explored separately. I aim to show how public health practices suggest limitations in some standard approaches to justice in health care, particularly those meant to be sensitive to social considerations.

I have decided to situate this dissertation in the liberal egalitarian framework. This framework is useful for many reasons. First, it provides several interlocutors with competing accounts of justice in health care. Second, this framework is the basis for some of the most prominent accounts of justice in health care. Finally, because of an overall commitment to social justice, this framework allows me to focus on how the social dimensions of health care impact our pursuit of justice. As a result, the liberal framework is a great starting point for analyzing how particular conceptions of justice in health care might address the specific concerns entertained in this dissertation.

While there are other laudable frameworks for theorizing justice, only the liberal egalitarian framework is entertained, and its commitments are presupposed.

Given this liberal egalitarian framework, in this dissertation, I explore what it means for the state to treat people as equals in health care. I defend the view that the relational egalitarian approach best expresses equal regard for everyone in the pursuit of justice in health care because it most fully captures health vulnerabilities and the reliance of individuals on others. I argue that the relational egalitarian approach accomplishes this goal by framing justice as ensuring that inegalitarian social relations are eliminated. In framing justice in these terms, I believe that relational approaches are best situated to address the justice-relevant concerns of different people in a way that ensures that they are all treated as moral equals in all contexts. This framing allows liberal egalitarians to adhere to their commitment to social justice in a much more consistent and comprehensive manner than is possible with distributive approaches.

Parameters of this Dissertation:

My argument is not an attempt to provide a comprehensive account of justice in health care. Instead, I am only defending a view about how liberals can adhere to their liberal egalitarian commitments in their pursuit of justice in health care. While the view I defend is compatible with many different frameworks, my objective is to see how it follows specific liberal egalitarian commitments given a minimal account of the social dimensions of health care. So, while similarities exist between the view I defend here and comparable views in other frameworks, only the liberal egalitarian framework is assumed.

Additionally, my focus on a social conception of health does not imply that this is the only conception relevant to the pursuit of justice in health care. My focus also does not mean that I take the state-citizen relationship to be the only one that is justice relevant. Rather, I am only making the case that distributive approaches to justice in health care are insufficiently attentive to these social dimensions in a way that undermines their commitment to social justice. There are several other actors and dimensions involved in any comprehensive health-care system. For example, physicians, non-physician medical personnel, state and local governments, public and private health-care provider organizations, medical researchers, pharmaceutical companies, and non-citizen patients are all involved. Competing conceptions of health come from other health-care sectors, including clinical, elective, palliative, and preventive care. Each of these other actors and competing conceptions of health presents considerations that have a bearing on how we ought to conceptualize justice in health care in a manner that might differ from the account I offer here. Nonetheless, my objective is to argue for an expanded focus on the

social considerations inadequately addressed in some liberal egalitarian accounts of justice in health care.

Finally, while the thesis of this dissertation relies on an account of how group-level moral harms are the focus of the state's interest in health care, I only hint at how these groups are constituted. Refraining from fleshing out such an account is neither an oversight nor a suggestion that such efforts are irrelevant to the consideration of justice. As the examples used in this dissertation suggest, social ontology in public health is both variable and highly relevant to determining the requirements of our pursuit of justice. Nonetheless, my focus is on making the case that when it comes to public health, the state's interests lie in the health of its citizens primarily to the extent that they are socially situated, including their membership in health groups. However, it is worth noting that my argument is premised on the idea that humans are social beings whose health is inextricably connected to others and their provision of health care. This dissertation provides the theoretical background for future explorations of the various connections within the context of health care.

In this dissertation, I use the term "health care" to refer to systems of practices, institutions, and social structures aimed at positive and negative health. This sense of health care includes clinical and non-clinical contexts and the various activities that have a bearing on individual and group health. While I do not attempt to provide a definitive account of health, I explore different views in chapter 3 and propose that a comprehensive account of justice in health care will need to frame health as, at least in part, social in nature. Similarly, while I provide a fuller articulation of public health in the third chapter, I use the term to mean those distinctly preventative health practices that take groups, and not individuals, to be their primary units of concern. Because these practices are often preventative and involve many non-medical interventions, I will also refer to them as paradigmatically non-clinical healthcare practices.

Structure:

This dissertation consists of 5 chapters. In chapter 1, I provide an overview of liberal egalitarianism and summarize the debate between distributivists and relationists.² I also describe the minimally plausible account of health and health care that helps to motivate my thesis. In chapter 2, I summarize distributive approaches to justice in health care. I argue that their reliance on an individualistic conception of autonomy undermines liberal commitments to social justice and results in citizens not being treated as equals. In chapter 3, I argue that these

² I use the term "distributivist" to refer to adherents of the view that justice is strictly a matter of distributions. In contrast, I use the term "relationist" to refer to the view that justice is a matter of egalitarian social relations.

failures of distributive approaches stem from a reliance on the distributive paradigm, which is based on an individualistic conception of health.

In contrast, I suggest that public health practices reveal a social conception of health that would allow liberal egalitarians to satisfy their commitment to social justice more fully. In chapter 4, I argue that the social conception of health revealed in public health is more consistent with relational approaches to justice in health care, suggesting that liberal egalitarians ought to be relationists in pursuing justice in health care. In chapter 5, I entertain some key objections that help elucidate my account's central claims before concluding.

CHAPTER 1

The Debate Between Distributivists and Relationists

1.1 Introduction

In this chapter, I provide an overview of the liberal egalitarian framework and its core commitments. After describing these shared commitments, I explain how differing interpretations of these commitments and their requirements have led to the distributivist and relationist camps of liberal egalitarianism. After providing a brief account of the basis for seriously considering the moral significance of groups, I suggest that the relational view best allows liberal egalitarians to satisfy their commitments while being responsive to health-relevant needs.

My argument in this chapter proceeds as follows. In section 1.2, I provide a brief overview of liberalism and its focus on individual freedom. I describe how the principles of individual freedom are part of an acknowledgment of how the pursuit of justice is a distinctly social endeavor. In section 1.3, I provide an overview of how social considerations lead to liberals adopting egalitarianism as a core commitment. In this section, I also consider the distributive and relational views that structure the rest of the dissertation. In section 1.4, I make a case for considering groups as legitimate units of moral concern, including that it is only by doing so that we can fully capture the health and justice-relevant concerns of individuals. I support this argument with a minimal account of the psycho-cognitive tendencies and socio-cultural practices surrounding the development of social groups. In section 1.5, I offer some concluding remarks.

1.2 Liberalism and the Pursuit of Justice

Liberalism in its various stripes is the view that liberty or freedom is an important if not paramount political value.³ For example, John Rawls (1999, 132) argues that individual freedom is so primary that the limitation of basic liberties is only justifiable to the extent that it allows those liberties to be reestablished. Different interpretations of the meaning of this liberal commitment to the value of freedom and how best to secure it are behind my explorations in this dissertation. Nonetheless, a few unifying commitments of the view offer a framework that will guide my exploration.

³ There is some debate in the literature about whether freedom and liberty are distinct concepts (e.g., Dworkin, 2011), but I will use them interchangeably and mainly use the term “freedom.”

At base, liberalism stems from an acknowledgment that humans are social animals existing in contexts where social cooperation is needed. While there are material and non-material benefits to this sociality, conflict will inevitably arise.⁴ This conflict can arise between persons, interests, rights, and values in ways that occasionally impinge upon the freedom of non-consenting others. My exploration of justice in health care touches on these various points of conflict.

For liberals, some social effort is required to prevent the impingement of this kind of conflict on individual liberty (e.g., Rawls 1999, 165). This view stems from the belief that the need for justice arises under conditions of moderate scarcity (Hume 1998, 15; Rawls 1999, 126-127). If this view is correct, justice is necessarily social and often involves distributions of some kind. In particular, the liberal view is that issues of justice often arise in contexts where everyone benefits, but no one can bring about the desired benefits on their own. Lawrence Becker (2012, 6) captures this aspect well in referring to justice as the moral practices encompassed by what we can accomplish better collectively than as individuals. While I present various articulations of the concept of justice in this dissertation, Becker's articulation is the most succinct sense in which I approach the concept. More explicitly, the sense of justice invoked within this dissertation is: *the set of collective practices deemed normative by a theory of right.*⁵

Liberals take justice to require collective mechanisms that protect against the impingement of the freedom of non-consenting others (Arneson 2013, 50; Pettit 2012). These mechanisms can themselves be coercive in the sense that they can lead to one's freedom being curtailed, often without explicit consent. The state is one of the primary vehicles through which social cooperation and societal coercion happen. But, liberals view the state's impingement of individual rights as acceptable. One burden for liberals is to explain why coercion by the state is permissible where coercion by individuals is not. The liberal response to this paradox is best captured by J.S. Mill's articulation of the *harm principle* (2003, 80). According to the *harm principle*, the only justification for impinging on individual rights is to prevent harm to others. I have argued that implicit in this principle is the liberal insight that individual rights and interests often conflict (Matose and Lanphier 2020).

However, the mere fact of this conflict is not sufficient to justify the harm principle. Instead, three related liberal approaches have been used to justify the harm principle: social interactionism, statism, and the collective

⁴ Examples of material benefits include cooperative food procurement, bodily security, and infrastructure. Examples of non-material benefits include love, friendship, respect, and comfort.

⁵ Further articulation of this conceptualization might be relevant for determining the full implications of my argument but is beyond the scope of my current exploration.

goods view. On the social interactionist view, certain human interactions lead to interpersonal harm that generates the requirement for social cooperation to prevent harm (Arneson 2013, 49). On the statist view, the state exists to ensure that citizens are regarded as equals and is therefore justified in its use of coercive power to this end (e.g., Anderson 2012, 14-16). The collective goods view focuses on how citizens cooperate to secure certain public goods such as security and public infrastructure (Arneson 2013, 53-55). On this view, the harm principle is thus justified because of its role in guiding the procurement of these collective goods.

While distinct, these three ways of justifying the harm principle show that liberals recognize how certain harms are a consequence of our sociality. This recognition leads many liberals to a commitment to social justice. Freedom is a paramount political value for liberals, and the individual exercise of one's freedom can impede the exercise of another's. If this is the case, social justice is a value through which everyone's freedom can be secured while harms between persons are reduced. This idea is behind Rawls' claim that justice is the first virtue of social institutions (1999, 513). Regardless of the approach taken to justify the harm principle, liberals generally recognize that the state must play a crucial role in securing freedom and preventing harm. For liberals, the state serves as a primary vehicle for public willing and collective action, which is why it has a particular responsibility to achieve the kinds of actions that are either too demanding or impossible for individuals to achieve. As I argue throughout this dissertation, this responsibility becomes more pronounced for liberal democracies since democratic states are manifestations of the will of citizens. This dissertation is consequently situated in political liberalism, and my focus is on what the state owes to its citizens.

As the preceding paragraph suggests, in the following chapters, I do not explore the justice-relevant concerns that are the responsibility of individuals. I believe that there are individual and non-state responsibilities in the pursuit of justice, but those are not the focus of this project. In addition to focusing on the state's responsibilities, I also focus on issues of justice that take both individuals and groups to be relevant units of moral concern. In some ways, this is a departure from standard approaches to liberalism that focus on individuals. For example, Mill (2003, 76) focuses on protecting "separate individuals" from the tyranny of the state. Mill believes this separateness of individuals is important because the "same things which are helps to one person towards the cultivation of [their] higher nature are hindrances to another" (2003, 132). The idea here is that justice is concerned with individuals in part because a focus on groups would obscure how differences between persons can result in the same intervention producing unjust consequences.

Rawls has a similar view, arguing that "a love of mankind that wishes to preserve the distinction of

persons, to recognize the separateness of life and experience, will use the two principles of justice to determine its aims when the many goods it cherishes are in opposition" (1999, 167). To put it differently, liberalism is committed to individuality because societies consist of imperfect persons whose interests can conflict in such a way that these persons cannot be considered in aggregate. Part of my objective in this dissertation is to show that despite intuitions to the contrary, maintaining this commitment to individuality is consistent with attentiveness to groups as legitimate units of moral concern.

1.3 Egalitarianism

I have so far argued that the liberal pursuit of justice is concerned with the moral implications of social interactions. However, a question remains as to how best to arrange society so that these social interactions are possible. Liberals inspired by Rawls maintain that justice obtains when society respects its citizens' moral equality and the liberal state is legitimate only to the extent that it expresses this respect. This view is generally called liberal egalitarianism, and debates about liberal egalitarian justice are concerned with what it takes for the state to express respect for its citizens' moral equality.

The views I explore in this dissertation are egalitarian in the sense that they are committed to the principle of equality, in the broadest sense, as a matter of justice. Madison Powers and Ruth Faden (2006, 50) capture this broad sense of egalitarianism as the commitment to the idea that some inequalities require moral justification. This articulation is helpful because it captures stronger versions of egalitarianism that take inequality to be always unjustifiable and therefore always unjust, to weaker versions like Rawls' that take inequality to be justified when it benefits those who are worse off.⁶ Within the spectrum of egalitarian views, there is a disagreement about whether equality is instrumental towards achieving justice or is itself an independent value (e.g., Arneson 2013).

This disagreement has led to different interpretations about the objectionable types of inequality. There is also a disagreement about what it means to have equality. One view, sufficientarianism, is that the kind of equality that should be sought in the pursuit of justice is the sufficient level of justice-relevant features necessary for a good life. For example, Martha Nussbaum argues that theories of justice must address how a society can secure decent social minimums for its citizens (2000, 125-128). Alternatively, the prioritarian view is that the pursuit of

⁶ For more in-depth exploration of the different types of egalitarianism, see (e.g.; Parfit 1997; Anderson 2012; Temkin 2002)

justice should address the needs of the worst-off in society (Parfit 1997; Rawls 1999, 65-73). Nonetheless, these different camps are motivated by the view that all persons are deserving of equal moral respect.

Distributivism

Egalitarian views about the best way for the state to express this equal respect for moral persons can be categorized as either distributive or relational. What distinguishes distributivism from relationism is a different understanding of how equality is achieved.⁷ Distributivists share the view that *the justness of a state of affairs is determined by looking at the distribution of justice-relevant goods*. While I will present a few articulations of this view throughout this dissertation to highlight its different features, this articulation captures the core of what I take to be the distributivist view. Given that all the views explored in this dissertation are also committed to egalitarianism, we can add that distributivists believe that such distributions should be equal unless the inequality can be justified. However, distributivists disagree about which goods are relevant to the pursuit of justice. For example, while some distributivists argue for the distribution of material resources (Dworkin 1981), some distributivists believe the relevant good is opportunity (Rawls 1999, 73-78; Daniels 2008) or opportunity for welfare (Arneson 1990).

Samuel Scheffler (2003, 31) and others have argued that this debate about the currency of distribution stems from the distributivist belief that inequality in one's holdings is permissible if it results from one's choices, a position known as luck egalitarianism. According to luck egalitarianism, citizens are understood primarily as recipients of social goods. The state's role is to eliminate, to the fullest extent possible, the impact of bad luck that befalls them through no fault or choice of their own (Arneson 2000; Tan 2012). In other words, for the luck egalitarian, the only inequalities that are unacceptable in the holding of some justice-relevant social good are those that result from bad "brute" luck (Dworkin 1981; Cohen 1989, 908). A consequence of this view is that some acceptable distributive patterns can misleadingly appear unjust when they are actually just. As a result, the focus on distributions might not be as helpful from a diagnostic standpoint as some distributivists suppose.

As suggested earlier, distributivists have attempted to address this challenge by defending approaches to justice that focus on distributing nonmaterial goods. For example, those advocating for the equality of opportunity or opportunity for welfare allow for unequal holdings of justice-relevant goods as long as all citizens are afforded

⁷ For ease, I will refer to distributive egalitarianism as "distributivism" and relational egalitarianism as "relationism." Similarly, I will refer to adherents of distributivism as distributivists, and adherents of relationism as relationists.

the equal opportunity to acquire these goods. This strategy is similar to the one used in the capabilities approach. On the capabilities approach, the state is responsible for ensuring that members of society are equipped with the capabilities that allow them to successfully utilize available resources to live a minimally decent life that is indicative of effective freedom (Sen 1979; Nussbaum 2003). The capabilities approach is thus distributive in the sense that it focuses on ensuring certain distributions. However, these distributions are taken to be instrumental to non-material capabilities that may not themselves be strictly distributive.

Relationism

The capabilities approach serves as somewhat of a bridge to the relational approach since it begins with the premise that distributions are an inadequate basis for evaluating the equality of a state of affairs or prescribing correctives in the pursuit of justice. Elizabeth Anderson (1999) and Samuel Scheffler (2003) have also argued that distributivists overlook that injustice sometimes resides in something other than unequal distributions. This claim is motivated by the insight that equal distributions can be consistent with treating citizens as less than equals. The relational approach is meant to correct this oversight by identifying how injustice can be the product of non-distributive factors like oppressive social relations. To put it differently, relationists believe that instead of requiring equal distributions, egalitarianism demands that members of society stand in relations of equality to one another.

Relationists disagree about exactly what it means to stand in relations of equality, but they generally advocate for the elimination of hierarchical social relations. Some relational approaches critique hierarchies of social standing, while others critique hierarchies of power. Relationists critical of hierarchies of social standing tend to focus on inegalitarian social relations that result in "stigmatization," which is the type of stereotyping that subjects people to ridicule, discrimination, shame, segregation, persecution, and occasionally violence (Anderson 2012, 40). For relationists, stigmatization is problematic because it creates social relations where some people are not treated with the due regard owed to moral equals.

Relationists who critique hierarchies of power are critical of social arrangements that result in the domination of some members of society by others. My view is that social arrangements provide the social context that structures the kinds of social relations at the heart of the relationist view. These social arrangements include formal and informal social roles, expectations surrounding these roles, the social meanings assigned to these roles,

and the set of norms that govern how people ought to perform given their roles.⁸ The relationist view focuses on whether the social relations that emerge from these social arrangements are structured so that people occupying different roles are afforded due respect as free and equal moral persons.

Relationists are concerned with inegalitarian social relations like those that result in domination or the significant control of others. The worry is that these kinds of inegalitarian social relations result in the kind of dependency of subordinates that leaves them vulnerable to the whims of those who exercise power over them (Nath 2020). As with the critique of hierarchies of social standing, the perceived problem with hierarchies of power is that they result in some members of society not being treated as moral equals.

While some have argued that relational egalitarianism is either distinct from or can be understood as related to moral registers other than justice (Miller 1997), I only entertain relational approaches relevant to the pursuit of justice in this dissertation. Paul Kelleher (2016) identifies three versions of the relational approach to justice. These three relational approaches are "equality of treatment," "equality of concern," and "equality of social relations." Equality of treatment involves one's causal relation to some need, where this relation determines one's duties to act in the pursuit of justice (e.g., Pogge 2004). Equality of concern determines duties to act in the pursuit of justice based on role-based relations such as the relation between parents and children. Equality of social relations determines duties to act in the pursuit of justice based on whether these social relations foster mutual respect between persons. This sense of relationism also emphasizes social structures based on the premise that such structures play an important role in determining whether persons treat each other with mutual respect.

Despite differences, these three ways of understanding relational egalitarianism are unified in their commitment to the idea that as a matter of justice, *the best way for the state to treat its citizens as equals is by guaranteeing that they stand in relations of equality that are free from harmful hierarchies*. This articulation allows for the possibility of unequal social arrangements that are justifiable as long as they do not produce relevant social harms. As with the conceptualizations of justice and distributivism, I will offer different versions of relationism to highlight different features, but I take this to be the core characterization of the view.

However, as I show more extensively in the fifth chapter, distributivists are skeptical that this characterization accurately captures the requirements of egalitarianism and our expectations of the state. Distributivists argue that relationism fails to capture the fact that distributions will always be part of any

⁸ This list is not exhaustive, and I discuss other kinds of social arrangements at various points in the dissertation. Other examples include where people live, how people access basic goods, etc.

comprehensive framework of justice. This point is conceded by many relationists, including Anderson (1999) and Schemmel (2011). This concession might lead to a worry that relationism is concerned with a different question than distributivism or is perhaps indistinguishable from it. Relationists argue that these concerns can be allayed in a way that allows the distinction between distributivism and relationism to remain as competing views of justice (Scheffler 2015). I also believe that these are two distinct views of justice and provide arguments throughout the dissertation to support this claim. That said, my focus is less on arguing for the distinctness of the views than showing the implications if each view is taken to be distinct.

1.4 Groups as Legitimate Units of Moral Concern

I have provided a non-exhaustive overview of the two main camps of the discursive community in which I have situated this dissertation. Of course, there are nuances and details that I have only hinted at, if not completely side-stepped, in providing this background. I have avoided further detail because my objective in this dissertation is not to provide a thorough taxonomy of the different iterations of liberal egalitarianism. Instead, I am interested in the question of whether distributive or relational views best capture liberal egalitarian commitments when it comes to health care. In the terms presented so far, this question can be reformulated as regarding how liberal egalitarians best adhere to their commitments to individuality, social justice, and equality in adopting an approach to justice in health care. These commitments could be satisfied by ensuring that citizens have the presumption of equal holdings of some justice and health-relevant good or stand in health-relevant relations of equality.

Admittedly, this framing means that my arguments might not extend to all social contexts relevant to a comprehensive and general theory of justice. This worry is found in views like that of Michael Walzer (1983), who argues that there are different, incommensurate spheres of justice. This dissertation is built on the premise that health care is a distinct enough sphere of justice such that we can talk intelligibly about "justice in health care." However, as will become apparent in later chapters, I depart from Walzer in that I believe that to the extent that there are different spheres of justice, the boundaries of these spheres are permeable and fungible. That said, a question remains as to whether my arguments are relevant to these other spheres or a general theory of justice. Providing an answer to that question is beyond the scope of the current project.

Instead, my view is that a compelling case can be made that liberal egalitarians ought to be relationists when it comes to health care, given how relationism best captures the justice-relevant features of health and health

care. This claim is defensible if we frame the dispute between distributivists and relationists as a disagreement about whether, as a matter of justice, the state best treats citizens as equals by ensuring certain quantitative versus qualitative measures for its citizens. More precisely, distributivists believe that to evaluate the justness of a state, all we need to examine is whether each citizen has enough of some justice-relevant holding. Relationists, meanwhile, believe that the justness of a state should be evaluated by examining the nature of the relations between people. In other words, relationists care about the quality of how people are faring relative to one another, even if they have enough of some justice-relevant good.

But comprehensive distributive approaches to justice in health care are more prevalent than relational ones. An examination of luck egalitarianism helps explain why this is the case. As Dworkin notes, his influential luck egalitarian approach:

Does not single out any group whose status has that position. It aims to provide a description (or rather a set of devices for aiming at) equality of resources person by person, and the considerations of each person's history that affect what he should have in the name of equality, [and] do not include his membership in any economic or social class. (1981, 340)

Dworkin is attempting to differentiate his approach from Rawls' difference principle, which he worries arbitrarily bases distributive strategies on the condition of the economically worst-off as a group at the expense of individual considerations. For Dworkin, the worry is that the difference principle could be insensitive to the needs of particular individuals because it focuses on generalized others. Similarly, distributive approaches are generally meant to provide a framework for addressing the justice-relevant needs of individuals.

To avoid insensitivity to particular needs, Dworkin and other distributivists theorize approaches to justice that are focused on individuals. A consequence of this focus is that accounts like Dworkin's are less capable of accommodating social groups as relevant units of moral concern. I will argue in chapter 4 that while many relationists also defend individualistic accounts, their approaches to justice are sensitive to the justice-relevant concerns of social groups in a way that is far more difficult for distributive approaches. Consequently, the dispute between distributivists and relationists is also about the appropriate unit of concern when evaluating matters of justice.

In chapter 3, I argue that the focus on individuals helps distributivists capture liberal egalitarian commitments in contexts like clinical care. This fit stems from the fact that clinical care is focused on individuals. But, as I go on to argue, the focus on individuals is ill-suited for capturing the diverse ways in which health is a feature of groups. Certain justice-relevant, group-based harms arise within the context of health care that might not be captured by focusing on individuals. If this is the case, my concern is that certain group-based harms in health

care should register as injustices for liberal egalitarians that might not be recognized as such in distributive approaches. As I state in the introduction, racial-health disparity is an example of this kind of group-based harm.

Unlike the distributive view, however, the relational view is framed in terms of intersubjectivity. Given this framing, a case can be made that the relational view is better suited to capture the kinds of unjust group-based harms that might not register on the distributive view. As I argue in chapters 2 and 3, even if our primary concern is with individuals, the connection between these group-based harms and individual interests is so strong that failure to attend to it would result in an insufficient response to the justice-relevant concerns of many individuals. The relational view is sensitive to how the health of individuals is inextricably tied to both social relations and groups. Thus, relational approaches are better equipped to register group-based harms appropriately. Consequently, I argue that liberal egalitarians ought to be relationists about justice in health care.

My objective is to explore more fully the bearing that group membership has on the pursuit of justice. Both relationists and distributivists tend to focus on the negative aspects of group membership, albeit in very different ways. As discussed earlier, relationists home in on the way that social grouping leads to harmful social hierarchies. Distributivists, on the other hand, worry that a focus on group membership can result in societies overlooking the justice-relevant demands of individuals. However, as I argue in chapter 4, the social dimensions of health suggest that social categorization, that is, group membership, is a key feature of society that can also benefit individuals.

My defense of the moral significance of groups relies, in part, on an account of how and why social groups come to be features of the lived experiences of humans and the significance that this sociality has for our health and pursuit of justice. One plausible account is that humans have developed a pro-social adaptation that results in social cohesion driven in part by a psycho-cognitive phenomenon called type-conditioning (O'Connor 2019, 45).⁹ Such type-conditioning is useful for social categorization, which helps humans solve different kinds of coordination problems like deciding who is responsible for procuring food and who is responsible for raising children.

However, this social categorization process is also the basis of the more pernicious psychological phenomenon of out-group bias, which is often the basis of group-based harms such as racism and sexism. Our sociality thus presents a paradox. On the one hand, societies with social groups become more efficient since they

⁹ See also (Berger and Luckmann 2011) for a discussion of how this process of typification differs depending on the level of acquaintance and perceived anonymity.

can systematize the way people are assigned to the various roles necessary for success and protection. On the other hand, when different roles are imbued with differential social meaning and exposure to risk, injustice can also occur (O'Connor 2019, 59).¹⁰ For example, occupational roles are associated with differences in esteem, income, and hazards. In addition, some occupations are associated with other group-based identities such as race and class. The result is that type-conditioning has a justice-relevant bearing on social arrangements in ways that also impact both individual and group health. I believe this account is plausible and provides an explanatory basis for understanding some of the features of public health discussed in Chapters 4 and 5.¹¹

1.5 Conclusion

What I have tried to do in this chapter is to provide a brief description of the liberal egalitarian framework and some of its core commitments. I have also tried to supply a minimally plausible account of the social conditions that allow social groups to count as legitimate units of moral concern. Liberal egalitarians are committed to individual liberty, social justice, and equality. In the coming chapters, I will argue that distributivists express this commitment by invoking the concept of autonomy while relationists invoke the concepts of relational autonomy and solidarity. I will also argue that in the pursuit of justice in health care, these core commitments are best satisfied by adopting the relational view. I believe the relational view is preferable because it does a better job of capturing the kinds of group-based concerns relevant to the pursuit of justice and have an important bearing on health and health care.

¹⁰ Cailin O'Connor provides a more fleshed out account of the positive and negative aspects of the psycho-cognitive basis of our pro-sociality in *The Origins of Unfairness*.

¹¹ This is not to claim that this is the only plausible account. See, for example e.g. Sundstrom 2003.

CHAPTER 2

Distributive Approaches to Justice in Health care

2.1 Introduction

As suggested in the previous chapter, the debate between distributivists and relationists is about how the state best treats its citizens as equals. This chapter explores how this debate has historically played out when it comes to health care. The question of justice extends to health care because of two features of the liberal framework. First, health is a primary natural good that makes it possible to pursue other goods (Rawls 1999, 97).¹² Second, as institutions of the state, healthcare systems are primary sites of justice since they are important loci of collective action. When it comes to health care, distributivists have argued that regarding citizens as equals entails that the liberal state must ensure the equal distribution of holdings such as patient rights, access to care, medical treatment, transplant organs, and health outcomes.

However, the most prominent accounts maintain that the reason for these distributions is ultimately to secure the equality of opportunity that is also the target of some general distributive accounts. Relationists, meanwhile, have argued that in order to ensure that citizens are treated equally in healthcare, the liberal state must eliminate inegalitarian relational phenomena like racism and oppression. Consequently, this narrower debate between distributivists and relationists is about whether the state best treats citizens as equals in healthcare by ensuring equal holdings of health-related goods or addressing the inegalitarian social relations that adversely impact health and health care.

To reiterate the overview provided in chapter 1, egalitarianism is the view that justice requires that individuals be made equal in some respect and that inequality in that respect might require moral justification. One reasonable view for adherents of egalitarianism is that justice calls for the equal distribution of justice relevant goods like units of wellbeing, income, wealth, opportunity, or status. On this view, the pursuit of justice should ensure that any inequality in the required distributions is morally justified.

In this chapter, I analyze some of the most prominent distributive accounts of justice in health care and show how they are framed to capture commitments to the liberal egalitarian principles of individuality, social justice, and equality. However, I aim to show that these approaches suggest that distributivists face a dilemma in

¹² See also Daniels 2008

their attempt to satisfy these commitments since their accounts are based on an individualistic conception of autonomy. I worry that this conception of autonomy is insufficient for capturing the needs of some individuals and inadequate for capturing why humans pursue health. If this is the case, then I believe the distributive view might be insufficient for satisfying the liberal egalitarian commitments to individuality, social justice, and equality.

My argument in this chapter proceeds as follows. In section 2.2, I analyze how prominent distributivists express a commitment to the liberal egalitarian principle of individuality through an individualistic conception of autonomy. In section 2.3, I explore how prominent distributivists express a commitment to the liberal egalitarian principle of social justice in a way that motivates concern for equality. In section 2.4, I further explore how their approaches to individuality and social justice lead distributivists to express a commitment to a narrow conception of equality. In section 2.5, I argue that distributivists operate on the assumption that the principle of individuality is paramount, an assumption that stems from the distributive paradigm. In section 2.6, I argue that the distributive paradigm's problems lead distributivists to rely on an impoverished view of autonomy and humanity. In section 2.7, I offer concluding remarks.

2.2 Autonomy, Individuality, and Distributions

Evidence of the distributive commitment to the principle of individuality can be found in the paradigmatic relationships of health care and their role in distributive approaches to justice in health care. The doctor-patient and researcher-research subject relationships are often taken to be paradigmatic in health care. In both kinds of relationships, individual concerns about autonomy, consent, and professional obligations have been taken to produce the most important philosophical questions. Consequently, theories of justice in health care tend to focus on the individual as the primary unit of concern, in part to address these kinds of questions. This focus on individuals has been accepted by both distributivists and relationists but is most prevalent in distributive accounts.

One way to understand the individualistic focus of distributive accounts is through the operative conception of autonomy on which they rely. For instance, Norman Daniels frames injustice, particularly regarding health disparities, as stemming from the unfair distribution of the socially controllable factors that affect health (e.g., 2008, 29-30). The Daniels view is that equal distributions of health-relevant goods are necessary for securing the equality of opportunity that allows for autonomous decision-making. According to Daniels:

Although society is obliged to protect health by providing reasonable medical services that people have claims to when in need, they do not have to use these services... Indeed, before undergoing treatment,

individuals must give informed, voluntary consent. (2008, 193)

Daniels is attempting to address whether preventative health measures are consistent with respect for persons as individuals. His response is that these health measures are appropriate if they allow for autonomy. Ronald Dworkin defends a similar view, arguing that "a just distribution is one that well-informed people create themselves by individual choices, provided that the economic system and the distribution of wealth in the community in which these choices are made are themselves just" (2002, 313).¹³

The conception of autonomy that is operative within the accounts offered by Daniels and Dworkin is almost identical to the one more fully developed in Tom L. Beauchamp and Richard F. Childress's *Principles of Biomedical Ethics* (2019).¹⁴ According to Beauchamp and Childress, "morality requires that we treat persons autonomously and refrain from harming them" (2019, 217). On this view, treating persons autonomously means respecting their ability to make decisions intentionally, with understanding, and without external control (Beauchamp and Childress 2019, 101). Even though Beauchamp and Childress (2019, 92) acknowledge that group membership is sometimes the source of morally and justice-relevant harm, their framework is built around obligations owed to individuals. More importantly, when individuals lack a sufficient level of autonomy, Beauchamp and Childress argue that they do not have the same entitlements as other individuals.

According to Beauchamp and Childress, there are different degrees of moral status such that:

Those who lack substantial cognitive and autonomy capacities will not have various decision-making rights such as the right to give informed consent that are enjoyed by those who are substantially autonomous, but they will still have rights to life and to health care. To say that they have a lower moral status is not to demean or degrade them. It is to recognize that they do not have the same entitlements that others have. (2019, 83)

While this view allows that those lacking the requisite level of autonomy still have some rights, Beauchamp and Childress do not provide further detail on what the source of that entitlement can be when they take such entitlements to be based on moral status. Nonetheless, the parallels between this account and that of Daniels and Dworkin is that autonomy is taken to be a strictly individualistic notion that is evidenced by valid consent.¹⁵

Another liberal egalitarian who takes a largely distributivist approach, Robert M. Veatch (1995, 203), has picked up how this prioritization of autonomy fails to provide a comprehensive account of respect for persons who are not fully autonomous. Veatch tries to offer a competing understanding of individuality, suggesting that

¹³ See also Dworkin 1993, 890

¹⁴ Beauchamp and Childress are not liberal egalitarians per se, but their account of autonomy is influential in distributive accounts and discussions of biomedical ethics more broadly.

¹⁵ Unqualified uses of the term "autonomy" in the rest of the dissertation will refer to this individualistic conception and will be contrasted in later chapters with the qualified "relational autonomy."

respecting persons includes the obligation to speak the truth, keep promises, and avoid killing others (1995, 204). However, Veatch also takes justice to be a matter of patterns of distribution (1995, 205), and he takes autonomy to be a principle that constrains justice (1986; 1991; 1995). On this account, each of these principles creates duties that are prima facie in the sense deployed by W.D. Ross (2003, 19-20). According to Ross, certain acts can be prima facie duties when they are obligatory, like proper duties, unless there is some morally relevant feature of the act that overrides the obligation.¹⁶ Consequently, Veatch takes respect for the kind of autonomy described by Daniels, Dworkin, and Beauchamp and Childress to be prima facie primary, even though he allows that it can at times be trumped by what he calls "social" principles like justice.

Like Veatch, Lawrence Becker also tries to acknowledge different levels of autonomy while emphasizing individual responsibility by focusing on the idea of habilitation. Habilitation is "the process of equipping a person or thing with capacities or functional abilities usually as relevant to a given environment" (Becker 2012, 7). On this view, each of us needs to be provided with physical, emotional, and psychosocial scaffolding to develop capacities along these dimensions that allow us to survive and thrive. While Becker's account of habilitation starts from the premise that individuals are not and cannot be self-sufficient and are particularly dependent on others at various stages of life, he concludes that habilitation must be primarily self-provided. This conclusion follows from Becker's belief that "the motivational and behavioral traits of basic health must include the sort of functioning required to prompt, accept, and use the habilitation provided—as well as to maintain or improve the environments themselves" (2012, 118). Additionally, Becker believes that these motivational and behavioral traits "must include the sort of functioning required to develop and sustain agency that is competent to provide such self-habilitation" (2012, 118).

Yet Becker argues that only a serious failure can hamper the development of the complex rational agency that he takes to be necessary and sufficient to acquire the motivational and behavioral traits needed for self-habilitation. On his view, this failure would have to be fairly serious since rational agency can be developed through minimally good physical and psychological health (Becker 2012, 75). Consequently, Becker believes that habitative failures that occur because of societal failures can be mitigated or even overcome by an individual's self-habilitation.

The appeal of this strong notion of self-habilitation is that it acknowledges the resilience that individuals

¹⁶ For example, keeping a promise is generally obligatory. But if keeping my promise would result in me failing to do something morally consequential like feeding my dog, then Ross' view is that I am not obligated to keep my promise. Prima Facie duties are thus not really duties since there are cases in which they are not obligatory.

can demonstrate in overcoming adverse social conditions. Yet, this emphasis on self-habilitation also seems to place an undue burden on individuals. As I have previously argued, part of what follows from this reliance on self-habilitation is that individuals are taken to be the kinds of primarily autonomous beings that can be held fully responsible for any social failures (Lanphier, Matose and Abdur'Rhaman 2020, 4). In other words, Becker acknowledges that societal failures can lead to failures in habilitation. But, because he believes in the power of rational self-agency and the possibility for self-habilitation, his account seems to ultimately fault individuals for any failures in their ability to habilitate properly. This stance is consistent with his view that habilitation “always requires considerable self-habilitation and thus considerable freedom for individuals, not only as they develop their agency but also as they subsequently exercise it” (Becker 2012, 146). Despite acknowledging the intersubjective nature of habilitation, Becker ultimately relies on a comparable conception of autonomy and ultimately defends an account that is as individualistic as the accounts of Daniels, Veatch, and Dworkin.

While these distributivists defend different health-relevant goods as the required currency of justice,¹⁷ they each provide distributive accounts that take autonomous individuals to be their primary unit of concern. Therefore, influenced by more general approaches to bioethics like that taken by Beauchamp and Childress, distributivists working on health care focus on questions of autonomy and consent. This focus helps to explain the emphasis on the doctor-patient and researcher-research subject relationships in distributive and bioethical discussions. For distributivists, interventions are framed almost exclusively in terms of their target recipient and how the freedom and agency of these individuals can be preserved through distributions. This framing reinforces the liberal egalitarian concern with the primacy of individual liberty and a worry that an inadequate focus on individuals would lead to a broadly dysfunctional society. Becker captures this worry in saying that the “description of a society whose basic or perfect justice does not centrally involve the well-being of individuals—individuals who are genuinely individuated—is the description of a dystopic sociopathology” (Becker 2012, 28). This view expresses the belief that theories of justice should have a worked-out account of the relationship between groups and individuals to preserve individuality.

2.3 Social Justice and Equality

As Becker’s statement about sociopathology suggests, while distributivists focus on individuals as the

¹⁷ E.g., opportunity for Daniels, insurance for Dworkin, eudaimonistic health for Becker, and things like organs and general health care for Veatch.

primary units of concern of health care justice, they are also committed to pursuing justice in society more broadly. For example, Daniels argues that the distribution of resources must adhere to “the limits set by fair terms of social cooperation” (Daniels 2008, 49).¹⁸ These limits are also governed by the need to provide other social goods and, the thinking goes, these limits would prevent the runaway distribution of resources to a select few at the expense of others. The fair terms of social cooperation also require the:

Publicity of rationales, a search for relevant reasons that are properly vetted by those affected by the decision, opportunity for revising decisions in light of new evidence and arguments, and assurance that these conditions are uniformly enforced” (Daniels 2008, 25).

These requirements suggest that Daniels takes distributive determinations to require some level of social engagement and consideration. For example, in discussing HIV/AIDS treatment, Daniels states that:

Of course, higher rates of treatment will not redress the inequality in prevalence itself. That would require changing gender-biased divorce and marriage laws, eliminating gender inequalities in property rights, eliminating school fees so that young girls would not have to resort to transactional sex to pay them, and so on. It would also involve public health measures that reduced sexually transmitted diseases and provided effective education about safe sex. (Daniels 2008, 303)

In other words, despite maintaining that justice is only concerned with distributions, Daniels seems to acknowledge that non-distributive, social interventions are necessary to address underlying health care injustice.

Dworkin also demonstrates a concern with broader social issues in his approach to justice in health care, built on what he calls the “prudent insurance” ideal. On this ideal, resources are allocated “between health and other social needs, and between different patients who need treatment” (Dworkin 2002, 311). These allocations are ideal in the sense that they are subject to the kinds of free-market patterns that might materialize if wealth were distributed adequately, people had sufficient health literacy, and insurance companies could not discriminate against people from certain groups.¹⁹ Like Daniels, Dworkin acknowledges the negative effects that social conditions can have on patterns of distributions, including otherwise fair ones. This acknowledgment means that Dworkin should be amenable to the social justice pay-offs of accounting for these challenges.

But the distributive commitment to social justice is perhaps best captured in Becker’s work. As discussed in section 2.2, Becker aims to provide a framework for producing just distributions built around the idea of habilitation. Becker’s account of habilitation suggests that rights and responsibilities are distributed between individuals and society. His view is that habilitation is an endeavor that applies to both individuals and their social

¹⁸ Footnote 28. This idea is based on Rawls’ discussion of a well-ordered society. See Rawls 1999, Ch. 8

¹⁹ Of course, Dworkin also recognizes that these conditions are clearly not met in actual societies. But the prudent insurance ideal is meant to create the conditions under which we come as close as possible to actualizing the same resultant circumstances.

contexts. These individual and social dimensions mean that failures in health are always, at least in part, failures in the collective processes and structures that are meant to provide us with the social scaffolding that is necessary for our health. On this view, habilitation entails attending to both the distributive and non-distributive social inequalities that have a bearing on positive and negative health. Becker's view thus suggests that justice in health care requires attentiveness to broader, non-health social dimensions. Becker also sees health as requiring a fair amount of social cooperation. This cooperation includes reliance on others to refrain from harm, the requirement of mutual aid, and the norms of fairness and reciprocity (Becker 2012, 147-9). These norms, Becker argues, rely on societal arrangements that promote the health of individuals.

2.4 Equality

As these examples suggest, in focusing on both autonomy and social justice, distributivists believe that inequality is generally morally objectionable and thus advance accounts that focus on equality. For example, although the distributive schema defended by Daniels allows for disparities in distributions to different individuals, that is because these disparities might allow for equality of opportunity. Daniels believes that these disparities are only permissible because people might need different amounts of the same holdings to avail themselves of the same opportunities. More importantly, Daniels believes that the point of meeting health needs is to keep individuals functioning as equal citizens (2008, 77).²⁰ This approach to justice in health care is consistent with the Difference Principle since inequality is permissible when it is more advantageous for those who are worst-off. But Daniels also takes his approach to be likely to eliminate disparities, therefore producing a more egalitarian society (2008, 55). For Daniels, then, the pursuit of justice is about treating people as equals and bringing about more equal social arrangements.

Veatch (e.g., 1995, 205) similarly believes that the obligation to distribute health care stems from the egalitarian premise that people are equal, and health-relevant goods ought to be distributed more equally. However, Veatch's approach is markedly different from that of Daniels in that he is much more in favor of equal distributions instead of disparate distributions that produce equal results. According to Veatch, egalitarians rely on the premises that: (1) humans have equal moral worth; (2) natural resources have moral strings attached; (3) there

²⁰ Daniels endorses the view of Elizabeth Anderson (1999), though, as I point out in chapter 4, they have different views of functionality.

is a prima facie responsibility towards equal distributions (1991, 85). Relying on this framework, Veatch argues that the pursuit of justice is satisfied once objective distributions are such that everyone has an equal opportunity to be healthy. But, by taking this approach to equal opportunity, Veatch leaves open the possibility that a just pattern of distribution might be one in which some people are left worse off than they might be otherwise. Nonetheless, he seems committed to the view that such a result would be in the service of treating people as equals.

Like Daniels and Veatch, Dworkin (2002, 311) favors an approach to justice that aims to provide equal distributions of resources to everyone while allowing individuals to make different decisions about how to use those resources in the pursuit of health and health care. However, given that he recognizes that we live in societies where individuals do not start with the same resources, Dworkin suggests that the state design a universal health care system that approximates the kinds of insurance decisions that the average person would make if resources were equally distributed. Dworkin allows some health care needs to remain unaddressed under these schemas, and some health inequalities might exist. Nonetheless, Dworkin thinks these inequalities would be justified since they would be consistent with initial equal distributions and reflective of individual choice (1993, 888). In other words, Dworkin takes these conditions to be expressive of treating people as equals.²¹

Becker is similarly focused on the requirements of treating people as equals and argues that truly egalitarian distributive policies could be limited to ensuring habilitation (2012, 103). Like Daniels, Becker also argues that distributions of health goods, even those that are not initially equal, produce a tendency towards equal distributions. Becker thinks that nonhierarchical social arrangements are the best way to ensure equal distributions given their presumption of equal moral worth of persons. However, he thinks this presumption is not a requirement.

According to Becker, hierarchical societies tend towards equality because the distribution of health-relevant goods requires an increasing number of other basically healthy individuals (Becker 2012, 146). Each of these individuals, in turn, would desire access to those health-relevant goods and be unwilling to accept their unequal distribution. In other words, the trend will be towards a wider distribution of basic health in society. Becker believes that the wide distribution of health, particularly with what he describes as an egalitarian normative

²¹ Dworkin's approach challenges Charles Mills' (2013) distinction between distributive and rectificatory justice. According to Mills, distributive justice is not attuned to rectifying distributive inequality given existing injustice. Dworkin, on the other hand, thinks it is. However, there might not be much to this disagreement given their compatible goals.

principle, protects against injustice (2012, 172).

2.5 The Distributive Paradigm of Justice in Health Care

These examples point to the various ways in which distributivists focus on the individualistic aspects of equality. But despite their differences, each of these distributivists takes an individualistic approach to the question of what it means to treat people as equals as suggested by the focus on individual function, health needs, and holdings such as insurance. This individualistic approach to equality is consistent with reliance on the respect for autonomy that I described in section 2.2. But it is worth investigating this individualistic focus given the liberal egalitarian and distributive commitment to social justice, a concept that intuitively seems to have several collective and relational features.

One reason for this individualistic focus suggested by Iris Marion Young is that distributivists frame their approaches within a distributive paradigm of justice. According to Young, the distributive paradigm includes the metaphysical presuppositions, terminology, questions, lines of reasoning, scope, and modes of application that “restrict the meaning of social justice to the morally proper distribution of benefits and burdens among society’s members” (1990, 30). This view of justice is based on a transactional conception of society, one in which individuals pass successively from one possessive relation with various material and non-material goods to another. Young takes this paradigm to dominate contemporary theories of justice, particularly distributive ones, but she suggests that it has two problems. First, the distributive paradigm is based on the idea that justice is about allocating material goods while ignoring the social forces that shape this allocation. Second, the distributive paradigm frames distributions as though they were static things instead of a function of dynamic social relations and processes (Young 1990, 30-31).

The first problem is evidenced by the fact that distributive accounts focus more on distributive patterns and their guiding principles and less on the distributing institutions and the social considerations that structure them. But if distributions are indeed functions of social institutions, it seems prudent to focus on the functioning of institutions. Distributivists attempt to do some of this work by addressing the social, political, and sometimes even the policy contexts in which distributive patterns materialize. But these efforts inadequately address both the social nature of public institutions and the broader socio-cultural factors that influence how these institutions are run.

Young possibly overstates the second problem. For example, Becker accepts that habilitation is a lifelong and continuous process. Daniels also acknowledges the fact that humans go through different life stages. But both

Becker and Daniels fail to capture how these stages are truly dynamic. Becker does not address how people can go back and forth between different states of health agency, and Daniels does not address how there are different lived experiences within each life stage. Dworkin perhaps does the best job of capturing this aspect of human experience by discussing insurance options for various life events that might arise. But even then, Dworkin, as with other distributivists, discusses life events as though they have only one dimension or are totalizing.²²

Young suggests that within the distributive paradigm, primacy is given to what we possess, and reification and individualism are assumed (1990, 8-23). The focus on possessions and reification is evident in the exclusive focus on distributions. Even when distributivists discuss non-material goods, they discuss them as though they were material or concrete things that one can possess.²³ Additionally, individualism is assumed within this paradigm when justice is reduced to the distribution of the holdings of individuals.

These features of the distributive paradigm are well-suited for Western-style biomedicine, particularly clinical care. For example, clinical care is taken to be best instantiated in the doctor-patient relationship. This assumption persists even though clinical care is now largely provided by teams.²⁴ The individual patient continues to be at the center of that care, and clinical care aims to identify, treat, and cure the pathologies and diseased conditions of that patient. In this context, the distributive paradigm can be seamlessly integrated, and it makes sense to discuss the distribution of medicines, access, beds, and other medical goods. It also makes sense to focus on the individual patient in this context since they are the ones that need treatment and care. If I have COVID-19, it is important to ensure that I, as an individual, have the health goods I need to fight the disease. Additionally, there are clear resource constraints in Western-style biomedicine that make it imperative to think critically about distributions in health care and how they affect individual patients.

This compatibility between clinical care and the distributive paradigm helps explain the dominance of distributive approaches to justice in health care. But the appropriateness of the distributive paradigm for clinical care is so undeniable that several relational accounts of justice in health also endorse some of its commitments. For example, Thomas Pogge (2004) and Paul Kelleher (2016) defend relational accounts that are ultimately meant to be in the service of just distributions. These approaches show that relationists care about distributions and that the distributive paradigm is so entrenched in Western-style biomedicine that there is a presumption towards a

²² For example, Dworkin discusses insurance for persistent vegetative states and dementia (2002, 313-314).

²³ This line of critique from Young seems to pose challenges for relational approaches, especially ones that focus on esteem.

²⁴ See, for example, the case of the COVID-19 patient who discovered that over a hundred health care workers had been involved in his care (Garcia 2020).

distributive conception of health. This presumption, in turn, leads to another presumption that justice in healthcare must also be distributive.

But what I would suggest is that while the distributive paradigm is attuned to the kinds of interests and concerns relevant in a relationship like the doctor-patient relationship, it neither exhausts them nor does it capture the ones that might be relevant to other concerned actors. One way to put this suggestion is to offer the non-profound observation that not all health activities happen in the clinic, and not everyone who is affected by these activities is a patient. Examining these other actors and health-relevant contexts should inform not only how we approach distributions but also helps reveal the non-distributive interventions that are required by justice.

2.6 An Impoverished Conception of Autonomy and the Individual

The two problems of the distributive paradigm identified by Young are a good place to start thinking about the dimensions of health care left unaddressed in the distributive paradigm. Recall that Young faults this paradigm for (1) failing to account for the social structures that partially determine the distribution of goods, and (2) failing to account for the dynamic social processes and relations that have a bearing on non-material goods. These shortcomings are evident if we consider how distributions impact people other than the patient or individual who is the target recipient. Failure to address these impacts results in impoverished conceptions of autonomy and individuals. In this section, I argue that these impoverished conceptions make it difficult for distributivists to satisfy their commitments to the principles of equality and social justice.

As discussed in section 2.3, some distributivists acknowledge that broader societal inequities can undermine just distributions in health care. Feminist critics have also pointed out that distributive discussions of elderly care often ignore the family dynamics that influence decision-making about that care. For example, Susan Okin (1989), Susan Wolf (1996), and Mary Mahowald (1993) have argued that distributive approaches fail to account for the burden these approaches place on women and children. In other cases, as with care involving some infectious diseases, this imbalance of burden also potentially means that caretakers face a disproportionate threat to their health.²⁵ These critics suggest that because patients within the distributive paradigm are taken to be autonomous individuals, interpersonal considerations that are material to the care of individuals are overlooked. As a result, a distributive pattern consistent with distributive approaches to justice could result in some patients

²⁵ For example, see Uden, et al. 2017 and Chou, et al. 2020.

receiving less care than if interpersonal considerations were considered. Inattentiveness to interpersonal considerations could also result in root causes of diseases and injustice remaining unaddressed.

Young's analysis suggests that distributivists have an unresolved tension between their attempts to acknowledge social factors relevant to distributions and their failure to address sociality within their accounts. Distributivists acknowledge various social dimensions of justice in health care but maintain that justice in health care is strictly about distributions affecting individuals. As stated at the beginning of this chapter, liberals take health to be the kind of good necessary for other goods. But if this is true, an inappropriate or misguided focus on distributions in health could potentially be more harmful than might be the case in other domains. This concern is heightened because the preferred criteria for determining distribution in health care tend to privilege those who are already socially advantaged, particularly in terms of health. For example, Becker's stance about the inevitable march towards equality suggests that he thinks there could be instances in which it is not urgent to redress problematic social arrangements.²⁶ Additionally, accounts like that of Daniels are premised on the biased idea that the preferable patterns of distribution are those that primarily prioritize young, non-disabled, socially well-situated, autonomous individuals.²⁷

Two features of the Daniels account highlight this bias: the reliance on the idea of normal functioning and the defense of a life-stage approach to resolving rationing issues. In terms of normal functioning, Daniels argues that:

impairments of normal functioning reduce the range of exercisable opportunities from which individuals may construct their "plans of life" or "conceptions of the good." This range of exercisable opportunities is reduced because some of our capabilities are reduced when normal functioning is impaired. These opportunities may be diminished even when society has made reasonable efforts to include people with disabilities. (2008, 35).

By normal functioning, Daniels means physiological processes characterized by what he calls "species-typical functions" like survival and reproduction (Daniels 2008, 38).²⁸ In other words, Daniels takes it to be a given that physiology necessarily determines opportunity.

This understanding of normal functioning, which is the basis for Daniels's approach to justice in health care, is premised on the idea that opportunities available to people with certain physiological and embodied features are inherently limited.²⁹ But, as Elizabeth Barnes (2020) argues, it is easy to conflate what is, in fact, true

²⁶ See the discussion of Becker's view in section 2.4.

²⁷ See the discussion of these accounts in section 2.2.

²⁸ Daniels uses the term biology, but it is more accurate to refer to physiology since some of the disabilities he is referring to, for instance those involving mobility, are not strictly biological in nature.

²⁹ I use the term physiological to mean the constellation of physical, biological, and chemical aspects of

with what is inherently true. In this case, it is easy for Daniels to mistake what happens to be true about the opportunities for people with certain types of embodiment or physiology as the same as what must be true. But the limited opportunities available to those with disabilities may be just an artifact of our social practices. As Martha Nussbaum (2003, 57) suggests, once we recognize how societies are designed to accommodate people with what Daniels calls “normal functioning,” we realize that the limited opportunities of others are socially contingent.³⁰ As a result, the privileging of normal function is a discriminatory and contingent bias that perpetuates the limitation of opportunities for some and not others.

Daniels also shows a bias against people with disadvantaged physiological and embodied statuses in relying on a life-stage approach to justice.³¹ He argues that “if we treat the young one way as a matter of policy and the old another way, and if we do so over their whole lives, then we treat all persons the same way” (Daniels 2008, 171). Daniels’ rationale for this approach is that we have different needs at different stages of our lives. But he thinks that if we are faced with a scenario in which resource scarcity requires us to choose between prioritizing the young or the elderly, we would certainly prioritize the young. He arrives at this conclusion based on the assumption that the elderly have had more opportunities in life, and they have less likelihood of achieving normal functioning. Consequently, Daniels privileges distributions to the young and healthy.

This kind of life-stages approach has many proponents, yet it suffers from several problematic assumptions. For instance, this approach is premised on the notion that older people have had more opportunities than those who are younger simply because they have lived longer. But consider, for example, a 60-year-old woman in the lowest socio-economic stratum who is in a racial minority and has no post-graduate education. Compare this woman to a 30-year-old man in the highest socioeconomic stratum who is in a racial majority and has an advanced post-graduate degree. It is not obvious to me that the mere fact that the woman is twice as old as the man is the appropriate starting point for evaluating their relative opportunities, let alone that this data point should be the sole basis of such an evaluation. Yet, the life-stage approach invites us to accept these assumptions. Some proponents of the approach might acknowledge that factors other than age could constrain one’s relative access to opportunity. But it is still not obvious that age or life-stage is the appropriate starting point for the relevant comparisons.

Another problem with the life-stage approach is its assumption of individuality. Consider, for example, a

embodiment as opposed to, for example, the purely aestheticized or performative aspects.

³⁰ Nussbaum’s example is that staircases are designed to accommodate the average human, not giants.

³¹ Daniels’s term is “lifespan,” but other terms for similar accounts are “fair innings” “life-stage” and “lifecycle.”

60-year-old man and a 30-year-old woman with the same socio-economic and racial profiles. While the ages are different, another difference is that the 60-year-old man is the primary caretaker for two school-aged children while the 30-year-old has no dependents. The life-stage approach tells us that the 30-year-old should be prioritized because of her age. But it is not clear to me that age is the appropriate, let alone sufficient point of consideration. To me, the care of the two dependents seems to be morally relevant. More importantly, it is not obvious that the older individuals in these scenarios would automatically ration their own care in a way that prioritizes their youth, as Daniels suggests.

Life-stage accounts like these and distributive accounts more generally often rely on evaluations of quality of life based on measurements like Disability (DALYs) and Quality-Adjusted Life Years (QALYs).³² However, as the examples above suggest, these evaluations privilege the lived experiences of those who are already socially advantaged. This privileging only reifies unequal social relations, making them harder to eliminate. Critics such as Faden (2000) and Young have argued that in reinforcing the hierarchies that come with such privileging, distributive approaches fail to address the problematic social relations that are often the source of distributive inequalities.

This failure is apparent even if we take health to be an objective and static state. But the failure is more pronounced when health is understood as part of our practices of meaning-making in which we negotiate how to accommodate different ways of being embodied in society. If the objective of liberal egalitarians is to design approaches to justice that result in treating people as equals, then those approaches should not be based on evaluative frameworks that are premised on and perpetuate the idea that some forms of embodiment and some lived experiences are inherently inferior. Another way of putting this claim is that liberal egalitarians must recognize a broader range of individuality for their approaches to justice in health care to result in the equal treatment of all citizens.

That said, some accounts of disability are not opposed to characterizing disabilities as limiting or adversely impacting some opportunities for those who are disabled. One such view is that of Barnes (2016), who argues that it is important to acknowledge how disabilities are sometimes limiting and challenging. However, Barnes maintains that this acknowledgment does not entail that disability makes the lives and opportunities of those who are disabled any less valuable. I think this is a big distinction. We can and should acknowledge and

³² DALYs are the number of life years lost to disability. QALYs are the number of life years in terms of duration, quality, and value based on the presence or absence of disease. See Beauchamp and Childress 2019, 183-184.

appreciate the difficulty and challenges of certain lived experiences without assuming that those lives have any less value. Given the egalitarian commitment of distributivists, this claim should not be controversial. Yet, distributivists contradict this commitment by defending patterns of distributions that exacerbate conditions for those who are already socially disadvantaged, essentially devaluing their lives and treating these individuals as less than equals.

The examples from disability and the elderly also suggest that the distributive focus on a narrow version of autonomy is inadequate for capturing the various ways that people live their lives. Take the life-stages example, for instance. If that idea is taken seriously, we need to acknowledge the feminist insight that all individuals require care during the book-end stages of infancy and old age. This care is often provided by young to middle-aged adults, which is part of the reason why health is valuable during intermediate life stages. In other words, one reason for valuing health is that it allows us to care for others.

Similarly, people with certain disabilities might be more reliant on others to live their lives, regardless of their stage of life. But even the young who are otherwise capable of Daniels' idea of normal function require care from others during episodes of serious disease. Given all of this, it seems inadequate to rely on the narrow conception of autonomy central to the distributive approach to justice. Instead, these examples suggest that health care and decision-making about health can be about more than just evidencing self-regarding consent. As a result, a narrow focus on this kind of autonomy and the individuality it suggests is likely to impede the liberal egalitarian pursuit of social justice and true equality for all.

2.7 Conclusion

In this chapter, I have aimed to show that despite an ostensible commitment to regarding citizens as equals, distributive approaches to justice in health care are ultimately self-defeating since equal regard in distributions is consistent with the unequal regard in other justice and health-relevant aspects. This paradox arises because people are not merely autonomous individuals, nor can they be reduced to their capacity to be holders of distributions. I do not deny that people are individuals, and, as patients, these individuals often require distributions that are appropriate for their health care needs. In addition, as Daniels and other distributivists have noted, health outcomes often are dependent on distributive patterns. These realities help explain the appeal of the focus on distributions to individuals. Nonetheless, to concede these points is not to say that distributions to individuals are the only or even most important considerations in addressing issues of justice in health care. Instead, as I have argued in this chapter, a comprehensive approach to justice in health requires a richer conception

of the individual as always socially situated.

I believe that many of the concerns raised in this chapter are addressed once liberals attend to the social dimensions of health. Distributivists acknowledge that these social dimensions exist and express a commitment to social justice more generally. Nonetheless, distributivists focus on a narrow view of what it means to be an individual and take social considerations to be beyond the scope of justice in health care. As a result, they defend approaches to justice in health care that entail that some individuals are not treated as equals. In the next chapter, I suggest that this failure can be addressed by considering the role of the state in the pursuit of both justice and health. Doing so shows that liberal egalitarians need a social conception of health for their accounts of justice in health care.

CHAPTER 3

Public Health and The Social Dimensions of Health

3.1 Introduction

In this chapter, I argue that liberal egalitarian approaches to justice in health care should be based in part on the social conception of health that is the foundation of public health practices. By operating on a social conception of health, liberal egalitarians can best satisfy their commitment to individuality, social justice, and equality for all persons in their pursuit of justice in health care. The social conception of health allows theories of justice in health care to address justice-relevant concerns that can be overlooked within distributive approaches that are based on an autonomous conception of health. My argument is based on insights gained from two public health examples. The first example is the public health practice of prophylactic vaccination, which is group-based, preventative, and provides indirect benefits to individuals. The second example is the public health focus on the social determinants of health.

Public health is generally the responsibility of state-run institutions. It reveals a conception of health that is group-based because it targets the health of populations and not merely individual patients. This focus on the health of populations suggests the impact of social arrangements on individual health. By addressing the health of populations, public health efforts lead to the protection of vulnerable individuals who might otherwise be inadequately protected under individualistic approaches. I aim to show that liberal egalitarians would be best served by adopting the social conception of health central to public health practice, given the advantages this conception affords in pursuing social justice and equal respect for all social groups and individuals.

This chapter proceeds as follows. In section 3.2, I make the case that the limitations of distributive approaches to justice in health care stem from a narrow focus on the individual concerns of clinical care. In section 3.3, I argue that public health practice provides a social conception of health that competes with the clinical conception of health. In section 3.4, I argue that in focusing on the social dimensions of health, vaccination programs, as public health practices, provide important challenges to the clinical assumptions common to distributive approaches to justice in health care. In section 3.5, I argue that the social dimensions of health help explain why the state ought to consider social factors in the pursuit of justice in health care. In section 3.6, I offer some concluding remarks.

3.2 The Clinical focus of the Distributive Paradigm

In chapter 2, I argued that distributive approaches to egalitarian justice operate on what Iris Marion Young calls the distributive paradigm (1990, 8-23). To reiterate, Young takes the distributive paradigm to be framed around the idea that justice is about distributions of benefits and burdens in society. Additionally, Young argues that the distributive paradigm is based on the ideas of reification and individualism. In other words, Young takes the distributive paradigm to be premised on the idea that the pursuit of justice is primarily about producing desirable patterns for the distribution of fixed material goods.³³ This distributive paradigm is appropriate for the justice-relevant objectives of health care that are targeted primarily at individuals. These objectives are clinical since they are directed at individual patients with concrete medical concerns. Because of the patient-centered nature of these objectives, the distributive paradigm is well-equipped to capture some concerns and interests of a variety of health care actors, including patients, their caretakers, and their physicians (Kenny, Sherwin and Baylis 2010, 9).

However, non-clinical objectives are pursued along with clinical objectives in any well-formed health care system. These non-clinical objectives involve aspects of health care that are not aimed at diagnosing and treating disease or the benefit of individual patients.³⁴ Some examples of these non-clinical objectives include research, public health interventions, quality assessment, and quality assurance activities. While each of these activities involves individual patients, what makes them distinct from clinical practices is that they aim at collective benefit and not the benefit of individuals. In aiming at this collective benefit, non-clinical health practices acknowledge the social context of health and approach the social context as an integral and pliable component of health care activities. If this understanding of the social context of health is correct and the pursuit of collective benefit is reasonable, approaches that overlook these non-clinical elements are likely to miss important health-relevant injustices.

Additionally, unlike clinical practices, which generate obligations and rights primarily through individualized relations like that between doctor and patient, non-clinical practices allow for the possibility of

³³ Young acknowledges that some distributivists advocate for the distribution of non-material goods, but she argues that there is still a form of reification that is assumed in these cases since these non-material goods are essentially taken to be static.

³⁴ As stated in the introduction, there are important differences between the related concepts of disease, illness, pathology, and medical abnormality see for example DeVito 2000 and Hofmann 2010. Nonetheless, my focus in this dissertation is on the ways in which such concepts, regardless of their content, are group-based or group-caused. Consequently, even though only the concept of disease is mentioned throughout, I believe that the claims made about disease also extend to illness, abnormalities, etc.

generalized and collective obligation. This distinction continues to be explored in the literature on the therapeutic misconception, which occurs at the intersection between clinical care and research activities. The misconception arises in a patient's failure to understand that some of these activities are not aimed at their clinical benefit and therefore do not generate the kinds of obligations that patients ordinarily expect clinical staff to fulfill.³⁵ For example, while some clinical obligations are owed to the research subject in biomedical research, the researcher's primary obligations are to society and the production of generalizable knowledge (Jennings and Arras 2008, 131-142).

The focus on individuals within the distributive paradigm provides a framework for addressing the justice-relevant concerns of patients and their treatment.³⁶ However, as the therapeutic misconception suggests, this paradigm seems ill-equipped to address justice-relevant considerations where there are other units of concern beyond the immediate individual. This shortcoming stems in part from an intentional move in distributive accounts to either ignore social considerations or take them to be merely indicative of whether distributive patterns are adversely impacted.³⁷ That is, distributive accounts are framed as though only individual holdings matter for justice without adequate consideration of whether, for example, those holdings are distributed through harmful strategies. Distributive accounts are also framed as though non-individual and non-distributive, but justice-relevant goals are not worthy of pursuit. Yet, non-clinical practices aim to pursue goals like generalizable knowledge as a matter of justice, producing paradoxes for distributive accounts involving health-related activities that cannot be captured in exclusively individualistic terms.

3.3 Public Health and the Competing Conceptions of Health

Along with biomedical research, public health is perhaps the best known non-clinical segment of health care and is therefore useful for exploring how collective and group-based concerns produce different considerations of justice than are available under the distributive paradigm. Public health is defined in part by its focus on population or group health instead of clinical or individual health (Pol and Thomas 2001; Powers and Faden 2006). In addition to focusing on groups, public health focuses on the prevention of illness and promotion of healthy behaviors. These additional focuses stand in contrast to the clinical focus on treatment. But both clinical

³⁵ See, for example, (Nuffield Council on Bioethics 2019, 20-21) and (Jennings and Arras 2008)

³⁶ I use the term "treatment" very broadly to include all aspects of clinical practices aimed at the individual patient including non-explicitly treatment-oriented activities such as palliative care.

³⁷ Daniels' view is still subject to this critique because he thinks social arrangements matter to health only to the extent that they affect the distribution of equality of opportunity (e.g., Daniels 2008, 53).

practices and public health practices can be broadly construed as focusing on improving health. This framing allows for a direct comparison of how these practices address the various justice-relevant concerns that arise in the pursuit of health.

Epidemiologists Theodore H. Tulchinsky, Elena A. Varavikova, and Joan Bickford (2014, 71) trace modern-day public health to Edward Jenner's discovery of the smallpox vaccine in the eighteenth century. Further advancements in public health were made in the twentieth century when changing material and conceptual conditions forced a re-envisioning of health and its requirements. According to Tulchinsky, Varavikova, and Bickford, these changes meant that medical practitioners had to start thinking about group-level and socially contingent factors to address the medical needs of patients. In other words, changes in material conditions forced a reconceptualization of the connection between health, disease, and health care.

The United States of America (US) is illustrative of how the improvement of material conditions can force a change in the conceptual framework of medical practice. In the twentieth century, the US population experienced significant improvements in standards of living and life expectancy. According to health demographers, Louis Pol and Richard Thomas (2001), these improvements meant that medical conditions like injuries that were acute in terms of their causes or duration gave way to medical conditions like cancers that were chronic in these respects. This shift meant that the demographic profiles of the people accessing medical care also changed from younger, otherwise healthy individuals to older individuals with more co-morbid or pre-existing conditions. The result was that certain medical conditions became less prevalent as patients became older and suffered from medical conditions whose proximate and distant causes were a life well-lived. In other words, what it meant to be healthy changed as what it meant to live and survive also changed.

Pol and Thomas argue that this shift in conceptualization happened because the etiological profile, or account of the causes of disease, changed.³⁸ On their view, when acute diseases were most prevalent, the etiology of disease was much more straightforwardly physiological. This prevalence helps to explain why the germ theory was an initially useful explanatory framework for practicing medicine. The germ theory and prevalence of acute disease supplied a fertile context for what Pol and Thomas call the medical model. The medical model frames disease as the affliction of an individual by acute, external causes such as accidents, germs, and viruses.

However, as material conditions changed the etiological profile of disease, the medical model no longer

³⁸ While some of the literature referenced in this chapter uses the biological sense of etiology, which refers to traits that are the basis for natural selection, I use the terms strictly in its medical sense as presented here.

provided a sufficient framework for thinking about health, disease, and the pursuit of treatment. According to Pol and Thomas, these new material conditions necessitated a new medical model that “emphasizes the interaction of biological factors, psychological states, and social and environmental conditions in the etiology and progression of health conditions within a population” (2001, 9). In other words, the practice of medicine now needed to account for both the physiological and social causes of disease. This new model also meant that medical intervention could happen at the societal level.

The advent of public health and the initial insights of germ theory had already ushered in the idea that an individual’s exposure to disease could be treated at the level of populations through interventions like mass vaccinations and communal sanitation. However, the emergence of certain chronic diseases like diabetes and obesity meant that disease came to be considered the result of complex factors, many of which are indexed to membership in social groups. More importantly, the fact that chronic disease could be understood in terms of group membership allowed the possibility of thinking about disease as something that can afflict groups and not just individuals.

This change in public health thinking challenges one standard conception of health as simply the absence of disease. Among philosophers, this standard conception is best captured by Christopher Boorse’s Biostatistical Theory of Health and Disease (BST). BST states that disease, which Boorse refers to as a pathological condition, “is a state of statistically species-subnormal biological part-functional ability, relative to sex and age” (Boorse 2014, 683). Given this account of disease, he argues that health is simply the absence of such conditions or, as he puts it elsewhere, simply “normal” functioning (Boorse 1987, 558-561). Boorse proposes BST as a non-evaluative account of health and, as this definition suggests, he frames health and disease as concepts based on biological function.³⁹ These features are meant to establish BST as an objective standard for determining whether a physiological condition counts as healthy. Given this objective, BST is compatible with some of the goals of both the medical model and the distributive paradigm.

Two features of Boorse’s account are relevant to my argument. One feature is that Boorse presents BST as a theoretical account of health, meaning that BST is meant to work the same way that a scientific or classificatory scheme works. In other words, Boorse intends for BST to provide a method of distinguishing between physiological statuses that count or do not count as diseased or pathological. Importantly, Boorse

³⁹ Although not the focus of BST, Boorse acknowledges several value-laden concepts like illness and what he calls “social disease-value hybrids like criminal insanity and disability. See (Boorse 2014, 684-685)

suggests that he does not intend for BST to be used as a standard for determining medical treatment (Boorse 2014). This disclaimer is important because, as Boorse himself notes, not every pathological condition *requires* treatment. Not everyone who has a pathological condition wants treatment. Finally, not everything that is practiced within the medical context *counts as* treatment.

The second feature of Boorse's account relevant to my argument is that BST is predicated on notions of both "normal" functioning and the idea of species-typical functioning because of its statistical nature. This feature of BST means that Boorse's account engages in comparative physiology that establishes approximations of idealized human types as standards for evaluating the pathological status of individual human functions (Boorse 1977, 556-558). To summarize, the two features of BST on which I am focused are first, that it is meant to be an objective account of health and disease, and second, it relies on notions of "normal" or species-typical functioning. I want to suggest that these two features of BST are problematic in a way that is made apparent by reflecting on the insights gained from the historical account of public health practices.

Since BST does not specify the causes of non-species-typical functionality, Boorse can accommodate some of the public health focus on chronic diseases and their complex factors. BST only stipulates that non-species-typical functionality is pathological. Nonetheless, the focus on the health of the populations instead of individuals in the practice of public health poses an apparent challenge to BST. With BST, Boorse focuses exclusively on physiological functions to determine health. However, there are other health-relevant, non-biological ways in which humans can be functional. For example, Elizabeth Anderson identifies "three aspects of individual functioning: as a human being, as a participant in a system of cooperative production, and as a citizen of a democratic state" (1999, 317). As the participation in cooperative production and democratic citizenship suggest, there are aspects of individual functioning that cannot be fully articulated as physiological functioning. And yet, impaired functioning in terms of cooperative production and democratic citizenship might capture aspects of disease that are either not immediately apparent at the physiological level or are otherwise not manifest in physiology (Boss 1997).⁴⁰ Furthermore, aspects of individual functioning like those highlighted by Anderson also suggest that human functioning is social in very important ways.

Boorse and other proponents of functionalist accounts of health might argue that only physiological function is health-relevant, hence the exclusive focus on physiology. This position seems reasonable if our sole

⁴⁰ I have in mind cases like people who are not able to do things like hold down a steady job despite the lack of an apparent physiological impairment or what has been called mass hysteria.

objective is to provide physiological criteria for a descriptive and scientific theory of health and medical practice. However, even this objective is undermined when we fail to account for the non-physiological aspects of individual functioning, including those that are social. The problem is that non-physiological features of individual functioning can be health-relevant when they identify certain physiological and social conditions as desirable or undesirable. This non-physiological designation has a bearing on whether and how some physiological conditions are treated. Pamela Reed (2019) and Bjørn Hofmann (2010) make this point in arguing that in different contexts, health has been conceptualized in positive and negative ways that often include both descriptive and normative dimensions. For example, many prominent accounts of health, including the contentious World Health Organization definition (WHO 1948), conceptualize health in terms of well-being, a fundamentally normative notion. Reed suggests that health often has both descriptive and normative dimensions, making it what Bernard Williams (2006, 129-131) would call a “thick” ethical concept.⁴¹

Public health foregrounds the thickness of the concept of health by emphasizing that etiology can be a morally relevant factor in evaluating physiological conditions. For example, preventative public health activities like handwashing affirm the value-claims that pathogens should not be spread and that there is a collective responsibility to prevent this spread. The second of these value claims suggests that those who fail to participate in these practices are proper targets of reproach when their actions lead to the illness of others. Importantly, value-claims like these suggest that there could be morally relevant distinctions between the various ways in which illness can befall a person. These differences are not reducible to the distinction between choice and luck that is the focus of luck egalitarians. Instead, this public health value-claim suggests that illness caused by the negligence of others is perhaps a particularly egregious form of morally relevant harm distinct from illness caused through either choice or bad option luck.⁴²

Public health also foregrounds the thickness of the concept of health by focusing on disease as a feature of health groups and social conditions. Conceptualizing disease as a feature of health groups involves value-laden judgments about how these health groups are constituted. For example, policies allowing social arrangements that systematically disadvantage members of some social groups suggest that members of the disadvantaged group are less valued. This idea is best captured by Anderson’s discussion of how principles of the state can express values

⁴¹ According to Williams, thick concepts straddle the fact/value dichotomy by picking out something factual about how someone has acted while at the same time assigning some value to that action. For example, the distinction between acting courageously versus rashly picks out the same factual or descriptive feature of an action *and* passes judgment about whether this action is laudable.

⁴² Similar observations have been noted by others. E.g., Pogge 2004, 156-157; Voigt and Wester 2015, 214 - 220.

like that some citizens are inferior to others (1999, 306).⁴³ The conceptualization of disease as a feature of social conditions goes a step further and frames some social conditions as less desirable than others in a health-relevant sense. For example, to suggest that living near toxic waste sites causes cancer is also to make a tacit claim about the undesirability of getting cancer and the housing arrangements and the factors that lead to them. Similarly, to suggest that frontline workers have a higher risk of becoming infected during a pandemic is to make claims about the value of those workers, the social reality of their work, and, perhaps, our priorities in distributing treatment and prevention.

Additionally, the decision of whether some physiological conditions count as diseases occasionally involves a value-laden determination of the epidemiological significance of these conditions. For example, if one person starts to laugh uncontrollably, the condition might be recognized as abnormal, but not necessarily a disease. In contrast, the same laughter in a large group of people can be recognized as an epidemic, a distinctly group-level classification of disease (e.g. Rankin and Philip 1963).⁴⁴ More importantly, because public health interventions are not straightforwardly aimed at the benefit of individuals, there is a sense in which each intervention can be understood as the expression of societal values. This expression manifests in the collective effort required for successful public health interventions. For instance, the provision of potable water affirms a society's desire to live in communities where most people do not have to spend time recovering from the effects of water-borne pathogens or worry about ensuring that their water is drinkable.⁴⁵ To reiterate, these are all examples of how the practice of public health becomes a vehicle for the assertion of different sets of values.

Despite claims that accounts of health like BST are value-free, critics have argued that functionalist accounts are inescapably evaluative (Kingma 2007; DeVito 2000; Murphy 2006). These critics claim that BST needs to be based on evaluative judgments, such as decisions about when a physiological condition counts as pathological and not simply a species-typical variation. This line of critique suggests that these kinds of evaluative judgments express the desirability of some conditions over others. For example, although it is species atypical to be taller than six foot five, the mere fact of being taller is not considered pathological. This species atypical

⁴³ For example, Anderson critiques distributive principles that mandate extra distributions to those with handicaps by framing handicaps as deficiencies or defects. Anderson argues that this framing marks the handicapped as inferior, which makes these principles an expression of pity, not dignity.

⁴⁴ Of course, this approach to disease classification has also been the source of injustice as with group-based diseases like hysteria (e.g. Tasca, et al. 2012) and drapetomania (e.g. Willoughby 2018). The problematic nature of these designations bolsters my claim about the role of value determinations in the practice of medicine.

⁴⁵ Issues like the Flint Water Crisis are thus indicative of the disregard expressed to the predominantly poor, Black folks. See Johnson, Key and Group 2018.

functionality is desirable in sports like basketball and volleyball. So, a value judgment is needed to decide what counts as pathological.

3.4 Vaccines and the Challenge to Approaches to Justice

So far, I have argued that both BST and public health involve value judgments that make social considerations relevant to conceptions of health. Nonetheless, Boorse (2014, 4-9) maintains that functionalist accounts of health like BST are value-neutral, suggesting that he takes health to be a concept that can be entirely objective.⁴⁶ On the other hand, public health involves strategies that acknowledge these social considerations and take them to be features that make health subjective in important ways. In this section, I argue that the view that health is at least partially subjective captures features of health that are important sites of justice. However, the problem is that these particular sites of justice can be missed if health is conceptualized in the strictly objective manner in which BST is intended. I believe a close examination of the social considerations arising in public health help to motivate this worry.

The paradigmatic example of a public health intervention is perhaps the prophylactic vaccine.⁴⁷ Modern vaccines can be traced back to Jenner's discovery of the protective effects of cowpox exposure.⁴⁸ Vaccines make a good test case for approaches to justice in health care since they require the kinds of distributions mandated by distributive accounts while relying on some account of health to address pathological threats. Additionally, vaccines play a crucial role in securing preventative health and are thus a significant part of health care. Yet vaccines are not clinical since they are neither always aimed at the benefit of patients nor is their effectiveness evaluated exclusively in clinical contexts. More importantly, because they sometimes introduce exogenic factors that might count as at least minimally pathological under a physiological conception of health such as BST, vaccines allow us to draw sharp distinctions between how distributive and relational approaches might address the justice-relevant concerns of public health.

The success of vaccinations is also often premised on the idea that individuals are members of

⁴⁶ Boorse does note that some health-adjacent like illness or disease could be value-laden, though he seems to maintain a distinction between these concepts as features of medical practice and health as the organizing concept under which we theorize what practices fall under the domain of medicine.

⁴⁷ There is also research on the possibility of therapeutic vaccines, but vaccines are still primarily prophylactic. My focus in this chapter is on prophylactic vaccines and all subsequent references to vaccines should be understood in this sense.

⁴⁸ A compelling case can also be made that vaccination can be traced to inoculation practiced in places like China, India, and Africa long before Jenner's experiments. See Boylston 2012.

populations subject to health-relevant social conditions. In other words, vaccine utility often depends on social relations. This dependency is evident in the concept of herd immunity, or the level at which protective factors are present in a health population such that a pathogen can no longer effectively spread from person to person. Achieving herd immunity is a crucial part of most vaccination efforts since populations often include people that, for various reasons, are reliant on the immunity of others to avoid pathogenic diseases.

There are some disputes about how herd immunity should be conceptualized and evaluated. Nonetheless, there is consensus among epidemiologists that vaccines are social interventions that can reduce the prevalence of pathogenic diseases within a population through non-individual immunity.⁴⁹ For example, a key concern for epidemiologists is determining the percentage of a population that needs to be vaccinated to achieve herd immunity, with standard strategies aiming for rates of 70 to 95% depending on the infectiousness of the underlying pathogen (Fine 1993, 265). That is, groups are taken to be immune without every individual within the group receiving the vaccine. This concern shows that, unlike standard clinical interventions, vaccines are interventions whose beneficiaries include groups.

These features of vaccines suggest justice-relevant concerns that will be handled differently by distributive and relational approaches. The Influenza (flu) vaccine is illustrative. The purpose of the vaccine is to prevent people from acquiring the flu virus. However, the flu virus has the greatest negative effects on children and the elderly. Children under the age of four get the Influenza B strain more frequently and suffer more complications and fatalities than people in other age groups. Adults over the age of sixty-five also tend to experience more flu-related hospitalizations and deaths than other adults. In addition, children younger than six months old and those who are immunocompromised are restricted from getting some versions of the flu vaccine due to the risk of harmful immune responses.

These factors result in an apparent paradox. Children and the elderly are the greatest beneficiaries of flu vaccination efforts because of their higher vulnerability to the virus, yet members of these groups are often not eligible to be the target recipients of vaccines. Instead, health-care personnel, household contacts, and caregivers are often prioritized in vaccination efforts so that protection is extended to members of vulnerable groups. This prioritization aims to ensure that those with robust immune systems do not endanger the health of members of the more vulnerable groups (CDC 2019; FDA 2019; NIAID 2017).

Distributive approaches to justice are equipped to handle some of the issues of justice that might arise in

⁴⁹ For a thorough critique of various conceptions of herd immunity, see Fine 1993.

vaccine strategies like the one just described. For instance, luck egalitarians might endorse a focus on the protection of children and the elderly since their greater vulnerability to the flu is not the result of any justice-relevant choice (Tan 2012, 100). Similarly, prioritarians can also endorse this focus on children and the elderly because it aims to help those worst off.⁵⁰ For example, Govind Persad, Alan Wertheimer, and Ezekiel Emanuel (2009) defend a version of the life-stage view that prioritizes vaccine distribution to younger people based on the fact that they have had fewer life experiences than the elderly.⁵¹ Robert Veatch also recognizes the need for vaccine distribution strategies to prioritize the needs of the most vulnerable, provided that these strategies do not lead to greater health inequities (Veatch 1991, 98-91).

Despite some compatibility with distributive approaches, vaccine strategies pose at least three challenges. These challenges are that vaccines are preventative, not always targeted at their intended beneficiaries, and finally, are evaluated at the level of groups. In being preventative, vaccines present a different holding than the kinds of distributions ordinarily proposed in distributive accounts. Unlike welfare, opportunity, or resources, which aim to provide a positive outcome, vaccines ultimately aim to provide a negative outcome, preventing disease. This difference is not necessarily a defeater of distributive approaches, and perhaps distributivists could attempt to recast their preferred distributions in terms of what they prevent. Distributivists like Daniels and Veatch might also make the case that disease prevention provides the positive outcome of health or even opportunity. Nonetheless, standard distributivist approaches generally frame the goal of justice as securing positive distributions, whereas vaccines have a stated goal of securing negative outcomes that do not appear to be straightforwardly distributive.⁵²

As I suggested in section 2.2, distributivists like Daniels and Veatch frame justice in healthcare in terms of distributions to which one is entitled, which makes sense given their commitment to justifying the distributive requirements of their accounts. But both Daniels and Veatch take other non-entitlement considerations to be outside the scope of justice. On their views, the requirements of justice are satisfied once positive distributions are satisfied. If the pursuit of justice stops once the positive goals of distribution are accomplished, then the

⁵⁰ Prioritarian views are distributive approaches to justice that deems inequalitarian distributions to be justifiable when such distributions are aimed at improving the condition of the most disadvantaged. See for example Parfit 1997 and Temkin 2002

⁵¹ For a longer discussion of life stage approaches like the fair innings view, see the discussion of Daniels' account in section 2.3. This particular account also straddles the line between distributivism and relationism as I discuss in Chapter 4. Part of its shortcoming is that it would not benefit the elderly who are also vulnerable.

⁵² This issue also points to a broader liberal debate about the different types of freedom. For example, Berlin 1969.

distributive view might be an inadequate framework for optimally securing the justice-relevant ends of preventative interventions like vaccines.

Vaccination strategies also challenge distributive approaches in that they involve prioritizing healthcare personnel, household contacts, and caregivers to benefit vulnerable populations. This prioritization suggests a different understanding of benefits and burdens than the one present in standard distributive approaches. The distributive paradigm is framed in terms of benefits and burdens to individual recipients of the relevant distribution. The discussion of Tiny Tim's case by G.A. Cohen (1989, 918) is a good example of this approach to benefits and burdens.⁵³ While Cohen allows that the welfare needs of others might override those of Tiny Tim, the only eligible recipient considered when Tiny Tim's welfare needs prevail is Tiny Tim.

A narrow conception of the unit of concern leads Cohen to suggest that Tiny Tim's welfare needs can be met with the provision of a wheelchair. No consideration is given to the possibility that addressing Tiny Tim's welfare needs might require interventions, distributive or otherwise, targeted at someone else. For example, maybe Tiny Tim's welfare needs would be better addressed by increasing his father's pay so the family can afford treatment. Or maybe Tiny Tim's welfare needs would be better addressed by providing emotional and educational support to his family. These alternatives, not considered by Cohen, show that other legitimate targets of intervention might directly benefit Tiny Tim. More importantly, the lens through which Cohen conceives the demands of justice means that he overlooks that because Tiny Tim's underlying condition is treatable, a wheelchair might unduly force Tiny Tim to continue to bear the burdens of his condition.⁵⁴

My point here is not to say that it is necessarily unfortunate to be in a wheelchair. A wheelchair might be the best way to meet Tiny Tim's welfare needs. Instead, I want to point out that even if our concern is with Tiny Tim's welfare needs, there are various distributive and non-distributive options available that do not seem to even occur on Cohen's view. These alternative options include strategies that do not require benefits and burdens to be carried by intended beneficiaries. The prioritization of healthcare personnel, household contacts, and caregivers in vaccination efforts is exactly the kind of intervention that suggests that justice might require focusing on someone other than the intended beneficiaries.⁵⁵ To reiterate, vaccine distributions are not always given to the

⁵³ This is Tiny Tim from *A Christmas Carol* by Charles Dickens (2016), not the talented musician who adopted the moniker. In the story, Tiny Tim has a treatable illness that his family cannot afford to treat given the poor pay given to his father by Ebenezer Scrooge.

⁵⁴ For example, Donald Lewis (1992) argues that Tiny Tim had a treatable and likely curable kidney disease.

⁵⁵ This strategy, which is found in other public health interventions like cash transfer programs that aim to provide indirect benefits to people other than the direct recipients of the distribution, may be consistent with Rawls' difference principle. The difference principle states that inequalities are unjustified unless they make everyone

immunocompromised individual who benefits from that vaccine. Instead, the burden of the intervention and its side effects are carried by others. In this way, vaccination efforts challenge the implied distributive assumption that the target of the distribution bears both its burdens and benefits.

Distributivists have a reasonable response at their disposal. They could argue that while the intervention's success depends on the distribution of a vaccine to those who are not the worst off, the justification for this distributive pattern is still the intended benefit, albeit indirect, to those who are the worst off (Lippert-Rasmussen and Lauridsen 2010). These intended benefits can be understood as a kind of opportunity for welfare or access to advantage, which can be understood as a non-material distribution. As a result, the relevant distribution is not necessarily the vaccine itself but the health benefits that accrue to the immunocompromised.

I grant that this response strategy allows distributivists to accept distributive patterns that produce an indirect benefit. However, the problem is that this strategy seems to require that we view some members of society in purely instrumental terms when it comes to the pursuit of certain requirements of justice. Distributivists might be willing to bite this bullet. But such a concession might allow for some deeply problematic cases where the benefit to others is used to justify morally problematic practices like telishment.⁵⁶

Finally, vaccination strategies challenge distributive approaches in that their success is gauged at the group and not the individual level. The idea of herd immunity helps to show this point. Recall that one of the commitments of distributive egalitarianism is that unequal distributions are *prima facie* unjust. While this commitment allows for approaches like prioritarianism, which justifies certain unequal distributions, it nonetheless makes it so that even reasonable unequal distributions are first considered unjust.

But, as I suggested earlier, one of the rationales behind vaccination strategies is the understanding that there are people who would be harmed by receiving certain vaccines. This possibility of harm means that it would be misguided to start from an assumption of equal distributions. Consider two views that frame the egalitarian requirement in vaccination strategies. The distributive view is that treating people equally in vaccines requires that everyone get a fair chance to receive the vaccine or that universal access should be granted.⁵⁷ This view is appealing if our objective is to maximize the number of people who get the vaccine. But the fact that a vaccine might be harmful to some or that other factors besides access might be relevant is either not considered or

better off (Rawls, *A Theory of Justice* 1999, 65-66).

⁵⁶ Telishment is the punishment of innocent persons to deter future wrongdoers. See Rawls 1955.

⁵⁷ See for example, Saunders 2019; Liu, Salwi and Drolet 2020; Vouking, et al. 2019

considered after the fact.⁵⁸

An alternative framing of the egalitarian requirement could be that treating people equally in vaccines requires some people to get vaccines and others to benefit from the vaccination of others. This way of framing the requirement allows that we strive to get as many vaccines as possible to those eligible while foregrounding that our efforts will also need to be sensitive to how it might be desirable or necessary for some people to get the vaccine. This alternative framing also captures the possibility that vaccination strategies can be most successful through selective targeting instead of universal coverage (Medlock and Galvani 2009).

As suggested earlier, even vaccines targeting extremely infectious diseases like measles achieve herd immunity at a coverage rate of approximately ninety-five percent (Watson 2018). Within that percentage of people who do not receive the vaccine are those who are most vulnerable to the pathogen or are otherwise too immunocompromised to get the vaccine. In other words, neither the moral nor medical success of vaccinations is necessarily dependent on universal access. Consequently, determining whether an individual has received a vaccine is of limited use in determining the satisfaction of the various goals of vaccination efforts. The concept of herd immunity reveals how health groups are relevant, if not the most relevant, units of concern for evaluating the success of the vaccine intervention.

Distributivists might respond in several ways. First, they might accept that sometimes health groups, instead of individuals, are legitimate targets of justice-relevant distributions. While this response is reasonable enough, it seems to require either of two problematic moves for distributivists. One possibility is that distributivists must accept that justice in health care sometimes requires us to do something other than ensure the individual holding of some justice-relevant good. The other possibility is they must adopt a more robust conception of individuals than the one offered under the medical model. To reiterate, the medical model presents patients as discrete individuals with objective medical conditions. I do not think distributivists can defend the kinds of group-level distributions necessary to account for the features of vaccinations I have been discussing and maintain this conception of individuality. Instead, I think they must accept that groups, too, can be legitimate units of moral concern.

As suggested earlier, those who defend non-material accounts of distribution might also counter by acknowledging that vaccinations produce group-level effects like herd immunity. Nonetheless, they might

⁵⁸ See for example, the problem of vaccine wastage with COVID-19 vaccines, which stems in part from issues related to trying to give vaccines to only vulnerable groups during the early phases (Gabrielson, Chen and Simon 2021).

maintain, the thing that is justice-relevant is the accrual of non-material goods like opportunity for welfare. This response is helpful because it highlights the distributive commitment to the holdings of individuals, not merely how those holdings came about.⁵⁹ Although this response avoids the problems that come with a group-based account of distributions, it brings us back to the problems posed by the second challenge: vaccines sometimes require distributions of burdens to someone other than the individual who benefits.

Without adequate responses, these problems posed by vaccinations suggest that distributive approaches might be inadequate to pursue justice in health. Where distributive approaches seem to have moral goals that are largely positive, public health's moral goals are at least in part negative. Where distributive approaches target their interventions at the individual who is their intended beneficiary, public health allows for the possibility that interventions can benefit someone other than those they are aimed at. Lastly, where distributive approaches take the individual as their primary unit of concern, public health allows for the possibility that the health group can also be the primary unit of concern.

3.5 Public Health, the State, and the Problem of Social Disadvantage

In section 3.4, I made the case that public health presents some challenges to distributive accounts to justice given its preventative, group-based, and indirect nature. But one might wonder why these challenges matter, particularly for justice. For example, the conception of health that emerges from public health might not directly impact how I, as an individual, operate. Alternatively, one might wonder why it matters that distributive approaches seem to insufficiently address some of the questions that arise in public health. In this section, I make the case that the social conception of health that emerges out of public health and the challenges it poses to distributive accounts matter because public health is the primary site for the state's interest in health. In other words, public health and the social conception of health matter because they are the lens through which the state approaches issues of justice in health care and other contexts. If distributive approaches are inadequate for public health, then they are likely inadequate for the state's pursuit of justice in health care.

To understand the claim that public health is the primary site of the state's interest in health, it helps to revisit the example of herd immunity. As suggested in the previous section, one implication of herd immunity is that the benefits of vaccinations only manifest at the group level. This means that herd immunity is a type of good

⁵⁹ Note this is true for views like luck egalitarianism since the evaluation of antecedent factors only happens when individual holdings are unequal.

that is distinct from the kinds of goods individuals can expect in clinical contexts. If, for example, I experience an ocular migraine, a physician can give me a prescription that gives me relief. In this case, prescriptions and relief are interventions and benefits that can be individuated. Herd immunity, on the other hand, cannot be individuated in this way. Expressions like “I feel herd immunity” or “we gave Tiny Tim a little bit of herd immunity” not only sound strange but are incoherent because of the irreducibly collective nature of herd immunity.

Herd immunity is a collective concept that takes the form of a collective or public good. Angus Dawson has highlighted three features of herd immunity that are constitutive of its public nature. According to Dawson, herd immunity is “indivisible, nonexcludable and dependent upon the cooperative actions of a group” (Dawson 2007, 164). This type of immunity is indivisible because it is not the sort of good that we can separate and give individuals. Herd immunity is nonexcludable because we cannot meaningfully exclude anyone from benefiting or participating in it. The immunocompromised person benefits from herd immunity just as much as the person of African descent who is wary of vaccines given histories like the Tuskegee Syphilis Study, who benefits just as much as the person who refuses the vaccine because they think it is used to track people.⁶⁰ Lastly, herd immunity depends on cooperative action because it is not the sort of thing that individuals can achieve on their own.

As stated earlier, the production of public health goods like herd immunity is one of the primary objectives of public health. The state has an interest in pursuing this objective because of its role as one of the main vehicles for cooperative action. As a vehicle for cooperative action, the state allows citizens to achieve feats like building health care institutions that they cannot achieve alone. But public health efforts administered by the state can be coercive. For example, the US Centers for Disease Control, a federal entity, establishes vaccination guidance, which is then codified into state laws in the form of mandatory vaccination requirements (Kroger, Duchin and Vázquez 2019). But if the harm principle is right and the only justification for coercive power is to prevent harm to others (Mill 2003, 80), public health efforts are justifiable only to the extent that they aim to prevent harm to others.

As suggested earlier, herd immunity satisfies this justificatory requirement in terms of the protection it provides to both immunocompromised and healthy individuals. However, this advantage is not limited to herd immunity. As the vaccine examples have shown, in providing an avenue for the pursuit of collective goods, public

⁶⁰ The Tuskegee syphilis study was a study that tracked the untreated progression of syphilis in African American men from Tuskegee Alabama. The study ran from 1932 until 1972 even though there were existing treatments during this time including the discovery of penicillin in 1947 (Brandt 1978). I explore the type of vaccine hesitancy that comes from these kinds of collective experiences in the fourth chapter.

health aims to prevent health-relevant harms that are addressable at the level of groups. Because the conception of health that is operative within the domain of public health already relies on the notion of health groups, group-based, health-relevant harms are legitimate targets of public health efforts.

Group-based, health-relevant harms resulting from social arrangements within the purview of the state are especially legitimate targets of public health efforts given the social determinants of health.⁶¹ These social determinants of health have been defined in a way that often points to the social embeddedness of individuals. For instance, the World Health Organization defines the social determinants of health as conditions into which people are born and circumstances “shaped by the distribution of money, power, and resources at global, national and local levels” (WHO 2020). This definition suggests the view that social factors that can impact one’s health are pervasive. Gopal Sreenivasan (2007, 23) conceptualizes these social factors as entirely outside of healthcare systems, but my view is that these systems are social institutions, and as such, they should be considered among the social factors that have a bearing on health. Beyond that stipulation, my goal here is not to endorse a specific account of these social determinants. Instead, my focus is on the idea that social factors have a non-negligible impact on health.

Much of the empirical work on the social determinants of health has been spearheaded by Michael Marmot and Richard Wilkinson, who have researched how health status is socially indexed. For instance, Marmot and Wilkinson (1999) argue that the social gradient in health is a widespread phenomenon. This gradient is summed up by the observation that, generally speaking, “the higher the social position, the better the health” (Marmot and Wilkinson 1999, 2). In showing the consistent positive correlation between social status and better health, Marmot and Wilkinson’s empirical data support the view that health is impacted by disparate social standing.

Some have argued that if social standing is the type of thing that can be rearranged and made more equal, then health inequalities stemming from disparate social standing are preventable since they can be changed through reasonable social effort. Margaret Whitehead’s view on this point has been influential in public health and bioethics. Whitehead’s view is that the wrong-making feature of health inequalities is unfairness, and this

⁶¹ Two dimensions of the social determinants of health are primarily discussed in the public health literature. The first has to do with disparities in health outcomes and statuses between countries, and the other has to do with within-country differences in these health metrics. Given my focus, any reference to the social determinants of health will be in terms of the within-country differences, though between-country factors are sometimes relevant to within-country considerations.

unfairness is constituted by the avoidability, and therefore preventability, of health inequality (Whitehead 1991, 219).⁶² Adina Preda and Kristin Voigt (2015, 29) add to this view and argue that avoidable health inequalities stem from social causes.

While I am largely sympathetic to these kinds of relational views, given the emphasis Whitehead, Preda, and Voigt place on the social dimensions of health, my view departs somewhat from their approaches. My view is that the avoidability of health inequality, while important, is a secondary wrong-making feature when it comes to the interest of the state. The primary wrong-making feature of health disparities in terms of the state's interest is whether there is some dimension of social disadvantage. Health inequalities that are the result of *unfair* social arrangements are morally problematic, but my view is that the state's interest in health necessitates a priority on addressing social disadvantage that results in the state treating citizens as anything other than equals.

This focus stems from the fact that the state has a monopoly over the formation and reproduction of the social structures responsible for creating many social determinants of health. This monopoly manifests in the state's control over infrastructure, public resources, and the policies that govern them. As Douglas Dover and Ana Belon have suggested, policies of the state have the power to “generate segregation, exclusion, and discrimination, while others may mitigate social inequities” (2019, 3). In other words, the state is uniquely situated to determine whether public infrastructures and resources ameliorate or exacerbate social disadvantage through the enactment and enforcement of its policies. This influence has even greater import within democratic societies since the state is supposed to be expressive of the will of the people. As a result, the failure of a democratic state to treat its citizens as equals is particularly pernicious since that would entail a fissure between citizens and the institutions that are meant to express their will.

Because of the extent of the state's monopoly on this kind of power, general social disadvantage is closely tied to social disadvantage. The idea of social exclusion helps explain the link between general social disadvantage and health. According to Marmot and Wilkinson, social exclusion captures the fact that the processes that fuel social disadvantage are:

dynamic and multidimensional in nature. They are linked not only to unemployment and/or to low income, but also to housing conditions, levels of education and opportunities, health, discrimination, citizenship, and integration in the local community. (1999, 208)

⁶² Pogge 2004 has a similar view that strongly correlates avoidability to the normative requirement to address health problems.

Thus, social exclusion suggests that social disadvantage in one area of life likely means social disadvantage in other areas, including health. If this account of social exclusion is accurate, it is reasonable to conclude that given the state's monopoly over social structures and its responsibility to treat citizens as equals, the state ought to eliminate social arrangements that create social disadvantage. The presence of this social disadvantage is evidence that the state is failing to treat its citizens as equals. In this case, the state's moral goals would be best captured in ensuring egalitarian social relations and not merely in terms of ensuring equal distributions. Additionally, by relying on accounts that do not address these features of social disadvantage that are so intricately intertwined with unjust broader social factors, distributivists could end up violating their commitment to social justice.

These ideas of social exclusion and social disadvantage help show why the account of health that emerges from public health is very distinct from the one that emerges from the medical model. Even if we want to focus on how social exclusion and social disadvantage affect individuals, these concepts frame that individuality in terms of one's broader social context. Additionally, since social disadvantage is defined in terms of social factors like housing, education, and discrimination, it is a notion that is both group-based and relational. In other words, the social determinants of health cannot be considered strictly in terms of the distribution of health goods to individuals. And yet, because of their impact on individual opportunity and whether people are treated as equals, the social determinants of health are directly relevant to the liberal egalitarian consideration of justice. As with vaccines and herd immunity, the social determinants of health suggest that health is itself a robust concept that is social in important respects. Additionally, the social determinants of health show how the state's interest in the domain of public health also commits it to address social disadvantage in domains in its control.

3.6 Conclusion

My goal in this chapter has been to show that the individual and clinical conception of health that is the basis for distributive approaches inadequately captures important aspects of health and what we might want to achieve in pursuing justice in health care. My focus on various aspects of public health throughout this chapter highlights how health has social dimensions that cannot be reduced to a merely constraining or defeating role that is separate from the pursuit of justice. Distributivists take this approach to the social dimensions of health by framing justice exclusively in terms of the kinds of holdings that are owed to individuals. Through my analysis of public health, I have tried to show that social institutions, social groups, and social conditions play an important role in health and its just pursuit.

To be clear, I am not trying to diminish the importance of clinical care, nor am I trying to suggest that individuals and their holdings are not important for the sake of justice. Instead, I am only trying to show that these components form an inadequate basis for theorizing justice in health care, even for distributivists. If liberal egalitarians care about individuals, they need an account of individuality that reflects their connectedness and interdependency. If they care about social justice, then they need to attend to how group-based factors might require collective action as a matter of justice. Liberal egalitarians operating on the kind of social conception of health that emerges from public health are better positioned to attend to these features of health than those operating on a medical model like BST. But it is only by attending to the social dimensions of health that liberal egalitarians can satisfy the goal of treating everyone as equals since these dimensions reveal the various ways people can be unequal, especially relative to one another.

CHAPTER 4

Relational Approaches to Justice in Health Care

4.1 Introduction

So far, I have argued that distributive approaches to justice in health care are inadequate for capturing justice-relevant, group-based social considerations. I believe this inadequacy stems from a medical or clinical conception that does not account for the social dimensions of health. I have also suggested that by focusing only on distributions to individuals, distributivists advance accounts that may insufficiently capture certain intuitive aspects of what it means to treat citizens as equals. Reliance on this clinical conception of health might also result in distributivists inadequately satisfying the liberal egalitarian commitment to social justice. The social conception of health operative within public health avoids these pitfalls, which stem from the clinical conception. As I argued in the previous chapter, the state's interest in the health of its citizens is primarily manifested in public health practice, which is intertwined with a concern for social justice. Given this interest and the state's importance in the pursuit of justice, I have made the case that when it comes to health care, liberal egalitarians best uphold their commitment to social justice by accepting the view that social considerations are ineliminable aspects of both health and justice.

In this chapter, I argue that where distributive approaches inadequately capture both the state's interest in the health of its citizens and how social considerations are relevant to the pursuit of justice in health care, relational egalitarian approaches can succeed in both respects. I argue that relational approaches generally rely on what I call a relational paradigm of justice. Unlike the framing of the distributive paradigm, the relational paradigm is framed as though the pursuit of justice should be aimed at securing egalitarian social relations between members of society. Within the relational paradigm, it is assumed that harmful social arrangements between interconnected people can lead to unjust social relations.

Not all relational approaches are appropriately responsive to the justice-relevant concerns of the social dimensions of health that I have highlighted. For example, some relationists focus on individuals as the primary units of concern or defend views meant to serve distributive ends.⁶³ Nonetheless, I am defending a particular kind of relational approach that picks out the features of the relational paradigm that best enable liberal egalitarians to

⁶³ See, for example, my discussion in section 2.3 about how relationists address the problem of distributions.

address the kinds of concerns I raised in the previous chapter. I suggest that the relational paradigm provides three core features that must be contained in the kind of relational approach that will be appropriately responsive to the justice-relevant aspects of the social dimensions of health. These three features are relational autonomy, social justice, and a robust conception of solidarity, which mirror the broader liberal egalitarian commitments to individuality, social justice, and equality. I argue that relationists relying on approaches that operate on these three features can best satisfy both liberal egalitarian commitments and the justice-relevant demands stemming from a social conception of health.

My argument in this chapter proceeds as follows. In section 4.2, I argue that the social dimensions of health revealed in group-focused public health provide an insight into the social dimensions found in the general experience of health and its pursuit. In section 4.3, I argue that addressing the injustice that arises in these social dimensions of health requires an account of justice based on a paradigm focused on social relations. In section 4.4, I argue that the concepts of relational autonomy, social justice, and solidarity are distinct features of this paradigm. In section 4.5, I argue that these three relational concepts are consistent with the liberal egalitarian framework and are necessary for a relational approach that can address the shortcomings of distributive approaches. In section 4.5, I offer some concluding remarks.

4.2 The Social Dimensions of Health

In chapters 2 and 3, I argued that public health practice reveals health as a social concept in the sense that it is always socially situated, and in some cases, it is group-based. This view suggests that social considerations are part of a robust conception of health and that achieving justice in health care for some individuals is not possible without attending to group-level dynamics. However, the social dimensions of health are not relegated to public health practice and its group-level unit of concern. Instead, as I argue in this section, the social dimensions of health that arise in public health are only components of the broader ways in which health is social. These social dimensions of health challenge the common assumption in bioethics and philosophy that, except in exceptional circumstances, patients ought to be considered full and autonomous moral agents.⁶⁴ This assumption contributes to the distributive paradigm's dominance in approaches to justice in health care since it implies that

⁶⁴ As I will argue later in this chapter, what is problematic is a particularly individualistic conception of autonomy, not the concept of autonomy per se. I will take this conception to be the standard view, which is different from what I refer to as “relational autonomy.” The unqualified use of “autonomy” refers only to the individualistic notion.

societal responsibility can end once individual responsibility kicks in. Without the assumption that individuals are full and autonomous, the distributivist view that the demands of justice are satisfied once individuals are regarded as equal in distributions is unjustifiable.⁶⁵ In this section, I try to show that there are generally social dimensions to health and its pursuit even when considered outside the domain of public health.

If we take health to have the social dimensions I have been arguing for, the idea of the patient as a strictly autonomous unit of justice-relevant concern is unjustifiable. Moreover, if we cannot justify conceptualizing patients only in terms of their autonomy, then approaches to justice that take individual, traditionally autonomous, patients as their sole or primary units of concern are likely indefensible. I aim to show that in the same way that public health sometimes requires attention to groups as units of concern, achieving justice in health care also requires attention to the social, non-autonomous relations necessary for health. I make this argument by considering four social dimensions of health, even for individuals who are generally considered autonomous. These dimensions are that health is parasitic on systems of care. It is parasitic on social structures. It can be dependent on others' health, and finally, it is often pursued for social reasons. I will explore each of these social dimensions of health in the rest of this section.

The first social dimension is that there are several respects in which health is reliant on systems of care. This reliance is most pronounced in the bookend life stages of childhood and old age when individuals are less able to secure their health independently, if at all. But health is also reliant on systems of care in the context of illness, disease, impairment, and disability, conditions that can happen at any stage of life. This reliance means that all individuals, even those who might otherwise be considered healthy or self-sufficient, depend on systems of care at some point in their lives. Within these systems of care, individuals are positioned relative to others on whom their care is contingent. Even theorists focused on autonomy implicitly acknowledge the relational nature of care by discussing autonomy within the paradigmatic doctor-patient and researcher-subject relationships.

The second social dimension is that health is parasitic on social structures for its provision and protection. For example, our health is reliant on adequate nutrition, which is dependent on our food networks. Through these food networks, we are reliant on the labor of others and their ability to handle our food correctly.⁶⁶ This reliance is most evident during outbreaks of food-borne illnesses like those caused by listeria and salmonella. Similarly, our

⁶⁵ This claim is especially true for luck egalitarians who take the expression of choice to be sufficient grounds for abandoning individuals to the fate of their choices.

⁶⁶ This is not only a modern phenomenon since even early hominoids were reliant on social cooperation to secure food, and the transition to farming led to vast changes to human health. For example, see McAuliffe 2016, Ch. 11.

health is reliant on social infrastructure. For example, we need roads to transport food and other health-relevant goods from places of production to the individuals who need them. Other forms of health-relevant infrastructure include trails, bike lanes, gyms, and athletic centers that allow us to attend to our physical well-being. Lastly, our health-care systems, including clinics, pharmacies, and hospitals, are also social structures. Given our reliance on these social structures, health should not be construed as something that is entirely within the control of individuals.

The third social dimension is that health is always susceptible to and dependent on the health of others. Systems of care suggest one way in which our health is dependent on the health of others. For example, these systems are only functional to the extent that caregivers are also healthy. This dimension of health also partially explains why the AIDS pandemic has been so devastating in sub-Saharan Africa. The loss of adult caregivers has created a projected twenty million orphans and thrust the elderly into caregiving roles when they would otherwise be primarily recipients of care (UNAIDS, UNICEF, and USAID 2004). The result has been catastrophic for social and health reasons, with children and the elderly unable to access basic familial health care, leaving them more vulnerable to various health risks (Clark 2006). As this example shows, there are strong social reasons for desiring the health of our caretakers. This dimension of health also explains why vaccine strategies prioritize health care workers and family contacts of vulnerable populations and why the prevention of mother-to-child transmission is a primary target in the fight against HIV/AIDS.⁶⁷ As discussed in chapter 3, infectious diseases can be transferred from the infected to the uninfected, including from caretakers to those within their care. Similarly, public health interventions like social distancing, isolation, and quarantine are all premised on the recognition that, in the case of infectious diseases, one's health can be undermined by social interactions.

The fourth social dimension is that health is pursued for social reasons. As the preceding paragraphs show, one motivation for desiring health is that our own health impacts our ability to care for others and prevent them from getting sick. But at a more fundamental level, the fact of our sociality means that we desire to be healthy to partake in social life. As any child who has ever had to be quarantined because of Chicken Pox can attest, one of the significant drawbacks of ill health is how it can prevent us from being able to participate in social activities that give meaning to our lives. In other words, we pursue health in part to enjoy the social things that

⁶⁷ For example, the US National Institutes of Health (NIH), Division of AIDS funds four clinical trials networks for research against HIV/AIDS. One of these networks, The International Maternal Pediatric Adolescent AIDS Clinical Trials Network, is primarily aimed at preventing the mother to child transmission of HIV (IMPAACT Clinical Trials Network 2020).

make our lives meaningful. Health is not some isolated private good that is pursued solely for its own sake. Without others and the social considerations and enjoyments they bring, it is unlikely that health would hold much significance for individuals. Similarly, as discussed in chapter 3, it is also an inescapable reality that our social arrangements have direct positive and negative impacts on our health. Where and how we live relative to others has a bearing on the kinds of illnesses and diseases that afflict us and when, whether, and how we can get health care.

These social dimensions, along with the group-based account given in chapter 3, support the idea that health is social in many justice-relevant respects. If this is so, our pursuit of justice in health care cannot be achieved without attending to these social dimensions. Approaches to justice that do not speak to these dimensions will be inadequate because they will neither secure justice for everyone nor address all health-relevant injustice for individuals.

4.3 A Relational Paradigm for Justice

Given the account of health I have offered, Egalitarians must pursue justice in health care within what I will call a relational paradigm.⁶⁸ Within this relational paradigm, justice is conceived of as establishing egalitarian social relations between members of society. This conception is based on the idea that harmful social arrangements between interconnected people can cause unjust social relations. Unlike the approach taken within the distributive paradigm, a relational paradigm is premised on the idea that justice has distributive and non-distributive dimensions. My account of the relational paradigm helps explain why relationists believe that inegalitarian social relations are unjust.

The distinction between social arrangements and social relations is an important one. As I suggested in section 1.4, humans have developed a pro-social, psycho-cognitive mechanism called type-conditioning, which leads to much of our group-based social arrangements. Group-based social arrangements help solve what Cailin O'Connor calls complementary coordination problems, which require social cooperation where members of different groups have different functions in accomplishing the same goal (2019, 20). If social categorization can be beneficial, the mere fact of social arrangements is not enough to result in injustice or harm. Instead, injustice occurs when these social arrangements have adverse outcomes like out-group biases and harmful hierarchical

⁶⁸ There is a concept with the same name in psychoanalytic theory which takes human relations to be “the core constituents of human experience” (Borden 2000, 354). However, my use of the term is an allusion to Iris Marion Young’s discussion of the distributive paradigm and is meant to be a contrasting concept to that paradigm.

relations. This distinction helps explain why relational egalitarians go beyond identifying social arrangements and explore criteria for *when* relations become unjust.⁶⁹

However, O'Connor argues that group-based social arrangements are negatively correlated with justice. Although social groupings are collectively advantageous, they often lead to discrimination, largely because of out-group biases.⁷⁰ If this description is accurate, then one plausible interpretation is that discrimination cannot be resolved simply by attending to distributions. This is not to deny that one way inequality manifests in harmful social relations is in terms of distributions. Instead, I am only suggesting that in addition to these distributive issues, the pursuit of justice would seem to require that non-distributive factors like out-group biases also be addressed.

This implication suggests that justice consists of distributive and non-distributive dimensions. For instance, Anna Deplazes-Zemp identifies five dimensions of justice: distributive, commutative, recognitive, reparative, and procedural (Deplazes-Zemp 2019, 3). If Deplazes-Zemp is right, then approaches that focus on only one of these dimensions would be inadequate when the target injustice touches on several dimensions. Distributivists would presumably reject accounts like Deplazes-Zemp's, given that their view is that justice is only about distributions. But, as I showed in chapter 2, distributivists appeal to procedural justice and accept that various non-distributive constraints are justice relevant. The reliance on non-distributive constraints suggests that distributivists at least implicitly endorse the idea that there can be non-distributive dimensions to justice. But if this is the case, the focus on distributions within the distributive paradigm could prevent the identification or adequate response to the non-distributive dimensions of injustice because of how it is narrowly framed around distributions.

But even if the distributive paradigm is inadequate for addressing the non-distributive dimensions of justice, this fact alone does not tell us that the relational paradigm is any better at this task, particularly in the context of health care. As I argued in chapter 3, when it comes to health care, the distributive paradigm is framed around the idea that justice is about distributions aimed at individual patients with relatively static and objective physiological conditions. Given these features and their suitability for addressing the justice-relevant needs of clinical practice, a competing paradigm of justice in health must either be more useful for achieving distributive

⁶⁹ See, for example, the discussion of relational discussions of when esteem hierarchies count as stigmatizing in Nath 2020.

⁷⁰ See O'Connor 2019, Ch. 5. To paraphrase O'Connor, once types are introduced, fairness is no longer the expected outcome.

justice or enable better responsiveness to the non-distributive dimensions of justice that are left unaddressed within the distributive paradigm.

To reiterate, I am proposing a relational paradigm based on the idea that justice ensures egalitarian social relations between members of society. This relational paradigm is premised on the idea that harmful social arrangements between interconnected people lead to unjust, inequalitarian relations. A relational paradigm allows justice in health care to be pursued in a more responsive way to the non-distributive dimensions of justice while still facilitating just distributive arrangements.

Two key features make the relational paradigm a better framework for addressing the non-distributive dimensions of justice. First, patients within the distributive paradigm are understood as autonomous individuals, while they are understood to be socially situated members of health-relevant groups in the relational paradigm. This contrast affects the types of interventions sought and how responsibility for health and care is attributed within each paradigm. Second, diseases are understood to be primarily acute, static, and objective physiological conditions in the distributive paradigm, whereas they are understood to be at least partially chronic, dynamic, and socially contingent within the relational paradigm. This contrast impacts how the sites of health care are understood and how priorities are set.

Global health emergencies like the COVID-19 pandemic emphasize how the contrast between the two paradigms leads to different treatment priorities and sensitivities to injustice. Within the distributive paradigm, greater emphasis is placed on individual rights, treatment, and outcomes.⁷¹ For example, White et al.'s model policy wrestles with the appropriate guidance for cases in which the provision of ventilators to the worst-off, i.e., the sickest, would mean distributing limited resources to a few people who are also less likely to survive long term.⁷² Given an emphasis on individual health outcomes, White et al. (2020, 5-9) argue that the sickest should be deprioritized for the sake of medical and distributive efficiency. While some distributive strategies like prioritarianism and sufficientarianism might arrive at a different conclusion, it is worth noting that White et al.'s cost-benefit analysis is consistent with distributivism more broadly. In other words, distributivism does not take the worst-case scenario of White et al.'s recommendations to be unjust. Additionally, policies like that of White et al. are insensitive to how those who are deprioritized are disproportionately members of marginalized and

⁷¹ E.g., Fairchild, Gostin and Bayer 2020

⁷² Black people are particularly penalized since they face higher rates of socio-economic challenges that lead to higher rates of co-morbid conditions, which then lead to worse cases of the COVID-19 disease. This combination means that members of this group are the most likely to get infected, they get the sickest, and they have the worst prognoses. As a result, this policy has a particularly adverse effect on members of this group.

disadvantaged groups (Yancy 2020).

In contrast, within a relational paradigm, greater emphasis is placed on community responsibility, preventative actions, and social justice (e.g., Matose and Lanphier 2020). This strategy allows for policies that are more responsive to the needs of the socially disadvantaged (Emanuel et al., 2020). Emanuel et al.'s recommendations are not strictly relational, and they also have their imperfections. For example, in scenarios like the ventilator case, they recognize non-distributive factors as justice-relevant but allow that distributive considerations might require the sacrifice of the needs of the worst-off. Nonetheless, Emanuel et al.'s relationally sensitive account allows them to more readily defend the seemingly intuitive stance that the sickest patients should always be prioritized in distributions. As a result, even if there are pragmatic reasons for failing to prioritize the sickest, Emanuel et al. can recognize this result as unjust. This stance allows this policy to potentially avoid producing the same additional harms against members of marginalized and already disadvantaged groups that result from the White et al. policy.

These policy examples demonstrate some of the challenges in trying to apply theory to real-world scenarios. Nonetheless, the fact that Emanuel et al.'s policy recommendations best capture the intuition that the pursuit of health care should prioritize the sickest speaks to the decided advantage of the relational paradigm for theorizing justice. By framing justice as having distributive and non-distributive dimensions, the relational paradigm provides a framework for addressing a fuller array of justice-relevant needs that arise in the pursuit of health care. Deplazes-Zemp provides a good starting point for thinking about these distributive and non-distributive dimensions. While Deplazes-Zemp's account acknowledges the relevance of distributions to the pursuit of justice, it also emphasizes how the non-distributive dimensions of justice stem from the dynamic nature of our social lives. As humans, we rely on others, encounter others, and are sometimes harmed by others, often based on our membership within particular groups. In the context of health care, these facts mean that our health is vulnerable to social arrangements, which also means that health-relevant injustice can occur within these arrangements.

The relational paradigm is a good framework for addressing the features of health care that are impacted by social arrangements because it is designed to pursue egalitarian social relations. This is to say that social relations are necessarily a function of our social arrangements such that they cannot be made more equal without attending to social arrangements. Attending to these social arrangements also requires us to attend to group-based injustices since our social categorization practices are a key part of these arrangements. These factors mean that

the pursuit of justice in health care needs to be attentive to the socially contingent factors that adversely impact individual and group health. The relational paradigm is attuned to these social dimensions of health in a way that helps relationists theorize a truly social conception of justice. In other words, the relational paradigm allows us to more fully pursue a society that is just in all health-relevant respects, not just those that are restricted to the distribution of health goods in primarily health care institutions.⁷³

The framing of the distributive paradigm impedes the recognition of justice-relevant social factors and group-based harms. As the Covid-19 example above suggests, when justice is conceptualized only in terms of distributions to individuals, unequal regard that is socially relevant is apparent in two ways. First, some individuals might automatically be deprioritized in the pursuit of efficient distributions, and second, harms occurring at the level of groups are illegible. Additionally, the narrow focus on distributions might mean that the broader social factors that lead to members of some groups being disproportionately represented among the sickest might remain unaddressed, especially to the extent that they are non-distributive. This means that even under distributive schema that do not automatically deprioritize certain individuals, root causes can perpetuate inequalities. Because of these shortcomings, approaches to justice in health care framed within the distributive paradigm insufficiently capture the liberal egalitarian commitment to social justice and the expression of equal respect for citizens.

If liberal egalitarians adopt a relational paradigm attuned to the social dimensions of health, then these shortcomings of distributive approaches can be avoided. The relational paradigm provides the best way to regard all citizens as equal and address the various health-relevant injustices that might confront individuals. However, as I have tried to show, a relational paradigm is incompatible with distributive approaches given their strict focus on the distributive dimension of justice. This incompatibility suggests that a relational paradigm necessitates some version of relational egalitarianism to address all instances of injustice more fully. If that view is right, then liberal egalitarians ought to be relationists and not distributivists about justice in health care.

4.4 Relational Autonomy, Social Justice, and Solidarity

As I argued in the previous section, the relational paradigm frames justice as being about, at least in part, social relations. Within health care, this means that greater attentiveness must be paid to the social dimensions of

⁷³ Another relevant articulation is that social justice is “the set of legitimate claims and obligations individuals have within a fair overall social arrangement” (Shelby 2007, 129).

health, particularly to the extent that these social dimensions of health are the cause or result of unjust social arrangements. In this section, I argue that the relational paradigm's focus on both the distributive and non-distributive dimensions of justice is the basis for the principles of relational autonomy, solidarity, and justice in all spheres of justice. These principles, which stem from the need for social cooperation, are explored in relational approaches to bioethics and reflect the belief that autonomy is not an individual notion. Social cooperation aims to produce collective benefit, and harm in one sphere of social life can impact one's well-being in other spheres. I suggest ways in which relational approaches to justice can address the social dimensions of health while reflecting the principles of the relational paradigm.

The paradigmatic doctor-patient and researcher-subject relationships have been the focus of bioethics because they have been the sites of morally problematic social dynamics. For instance, bioethicists have expressed concern about the medical paternalism of doctors being substituted for patient choice, and they have worried about the human subjects' experimentation done by Nazi doctors without the consent of those imprisoned in concentration camps. Bioethicists have also focused on the Tuskegee Syphilis Study's exploitative denial of available and effective penicillin to syphilitic African American men. Each of these cases essentially involves abuses by a socially privileged group against a socially disadvantaged group. Even the harvesting and proliferation of Henrietta Lacks' cells without her knowledge or consent was likely because of her social disadvantage in being Black, poor, and a woman in the early nineteen fifties in the United States of America.⁷⁴ Bioethicists have long recognized that social considerations like those suggested in these examples should be factored into ethical reasoning about health care. This is the same strategy that is employed by relational egalitarians. This recognition, particularly considering the influence of Feminist theory within the discipline, helps explain the growing emphasis on relational approaches within bioethics.

Most relational egalitarians working in the liberal tradition offer only limited theories of justice in health care, so the broader relational approaches found in bioethics offer a better starting point for exploring the features of a comprehensive relational account of justice in health care. While not always situated within the liberal framework, relational approaches in bioethics tend to identify liberal distributivism as their main target of criticism. As a result, these bioethical approaches are useful for identifying features of a relational approach that address the normative considerations relevant to liberal egalitarian pursuits. Relational approaches in bioethics demonstrate broader relational priorities based on relational autonomy, social justice, and solidarity. I will review

⁷⁴ See Skloot 2010.

each of these principles before exploring what they portend for relationists in the liberal egalitarian tradition.

The first principle central to relational approaches in bioethics is the principle of relational autonomy.⁷⁵

While these accounts differ in detail and emphasis, they generally propose that the autonomy of individuals is based on social relations. For example, Françoise Baylis et al. argue that:

Relational autonomy embraces (rather than ignores) the fact that persons are inherently social and politically and economically situated beings, raised in social settings, who learn to develop their interests and values in conversation with other social and politically and economically situated beings. (2008, 202)

Bruce Jennings similarly endorses relational autonomy, arguing that “as there are kinds of practice or activity that by their very nature cannot be done alone, so there is a kind of freedom that subsists not in separation from others but through connection with them” (2009, 130).⁷⁶

This relational conception of autonomy is markedly different from the dominant view defended by Tom L. Beauchamp and Richard F. Childress. According to Beauchamp and Childress, autonomy is a feature of individuals based on cognitive capacity as evidenced by the ability to make decisions intentionally, with understanding, and without external control (2019, 101). This characterization of autonomy suggests that the individual is the unit of concern, and the primary, morally salient considerations are whether that individual can make uncoerced decisions. In contrast, the relational conception of autonomy emphasizes the social embeddedness of individuals such that social relations and social groups are legitimate units of concern. Additionally, the relational conception of autonomy allows that social, non-cognitive considerations are also morally salient. The relational conception of autonomy simply invites us to consider how social factors impact the autonomy of individuals. In other words, neither does the patient exist in isolation nor does attentiveness to the social require us to ignore individual considerations.

The second principle central to relational approaches in bioethics is social justice.⁷⁷ Perhaps the most prominent of these approaches is that of Madison Powers and Ruth Faden, who argue that a commitment to social justice “attaches a special moral urgency to remediating the conditions of those whose life prospects are poor across multiple dimensions of well-being” (2006, 82). Baylis et al. agree with Powers and Faden, arguing that:

In practice, inequalities among these dimensions [of well-being] are pervasive and interrelated, such that failure to achieve a sufficient level in one dimension very often results in a failure to achieve a sufficient

⁷⁵ See, for example Baylis, Kenny and Sherwin 2008; Pritchard-Jones 2017; Jennings, Wertz and Morrissey 2016; Jennings 2019; Kenny, Sherwin and Baylis 2010.

⁷⁶ Although liberal egalitarians generally tend to defend individualistic accounts, this view is consistent with the views of liberal egalitarians like Philip Pettit who acknowledges that individuals do not enter the world fully and independently formed.

⁷⁷ See for example Newdick 2017; Peter 2001; Nussbaum 2003; Jennings 2016; Jennings 2019; J. P. Kelleher 2014.

level in other dimensions. (2008, 203)

Influenced by the accounts of Iris Marion Young (1990) and Elizabeth Anderson (1999), Wendy Rogers (2006) has also offered an account of social justice that posits the elimination of discrimination, oppression, and domination as requirements for preventing disease. As suggested earlier, these accounts emphasize how the pursuit of justice in health care requires justice in the non-health-specific spheres of society. The relational view is that justice in health care is predicated on justice in all other domains of society. While these approaches offer varying views of social justice and its requirements, this idea is central.

The third principle central to relational approaches in bioethics is solidarity.⁷⁸ Jennings suggests that solidarity involves both the recognition of persons and respect for their rights. According to Jennings:

Solidarity is the practice of affirming the moral standing of others—their rights, freedom, dignity, and membership in the communities of consideration... Membership solidaristically acknowledged and attention caringly sustained are two of the principal social and moral determinants of health and human flourishing. (2019, 9)

Elena Buyx and Barbara Prainsack offer a more streamlined account of solidarity distilled from their landmark report on the emergence of the concept in bioethics. They suggest that “solidarity signifies shared practices reflecting a collective commitment to carry ‘costs’ (financial, social, emotional or otherwise) to assist others... solidarity [is] a practice and not merely an inner sentiment or an abstract value” (Buyx and Prainsack 2012, 80).

As with the two principles discussed so far, there are some differences between these accounts in their conceptualization of solidarity. Nonetheless, these accounts present solidarity as involving collective practices that recognize persons and their differences while respecting rights. The principle of solidarity allows individuals to band together for collective action while those individuals respect each other’s differences. Buyx and Prainsack’s account also helpfully points us to how the conceptualization of solidarity in bioethics has also acknowledged health care as involving the collective assumption of costs incurred to help others. Additionally, Buyx and Prainsack point out that although the collective assumption of these costs can result in collective benefits, these benefits are not a requirement for solidarity.

4.5 Towards a Liberal Egalitarian Approach to Justice in Health Care

These principles of relational autonomy, social justice, and solidarity, as articulated in bioethics, suggest

⁷⁸ See, for example Prainsack and Buyx 2011; Baylis, Kenny and Sherwin 2008; Kenny, Sherwin and Baylis 2010; Meulen 2016; Jennings and Dawson 2015.

how liberal egalitarians operating within the relational paradigm can offer an account of justice in health care distinct from distributive approaches while addressing sources of injustice that are beyond the scope of distributions. These principles provide the basis on which relationists can fully satisfy their liberal, egalitarian, and relational commitments regarding health care. However, as acknowledged earlier, there is a paucity of fully theorized relationist accounts of justice in health care. In this section, I draw on the relational paradigm articulated in section 4.3 and the principles of relational approaches in bioethics articulated in section 4.4 to propose an account of the requirements for a comprehensive approach to relational egalitarianism.

As stated in the first chapter, Elizabeth Anderson offers one of the most prominent and extensive relational egalitarian accounts of justice. Given its prominence, Anderson's account provides a useful barometer for evaluating the consistency of the principles of relational autonomy, social justice, and solidarity with a liberal egalitarian set of commitments. According to Anderson (1999, 289), the primary goal of liberal egalitarian approaches to justice is to express equal respect and concern for all citizens. Anderson goes on to suggest five desiderata that are necessary to achieve this goal. She states that relational approaches to justice must first identify certain goods to which all citizens must have effective access throughout their whole lives. Second, these approaches must justify such guarantees of lifetime accessibility without resorting to paternalism. Third, these approaches must offer remedies that match the type of injustice being corrected. Fourth, these approaches must uphold the responsibility of individuals for their own lives without passing demeaning and intrusive judgments on their capacities for exercising responsibility or on how well they have used their freedoms. Fifth, these approaches must supply principles for collective willing – that is, for what citizens should will together, not just for what each can will individually (Anderson 1999, 301-314).

Anderson believes these desiderata allow relationists to express equal respect and concern for all citizens. The first and third desiderata involve distributions to individuals, showing that relational approaches express concern for distributive justice. The fourth desideratum also demonstrates a focus on the individual as the unit of concern. These features of Anderson's account suggest that distributive and relational approaches share a concern for individuals. This shared concern means that relational approaches like Anderson's might encounter some of the same problems faced by distributive approaches. For example, while the fourth desideratum has the virtue of respecting individual choice and responsibility, it might also fail to register how individual choice is affected by social factors. The fact that relational approaches have these individualistic concerns means that distributive approaches do not provide any advantage over relational ones regarding their two defining features, a concern for

individuals and a concern for distributions.

But the second and fifth desiderata proposed by Anderson suggest essential points of departure from distributive approaches. The second desideratum starts to get at the insight present in bioethical inquiry that relations themselves can be sources of injustice, even if we achieve distributive justice. The fifth desideratum points to how the pursuit of justice must be a vehicle for collective willing. Neither of these features is explicit in distributive approaches yet seem to be important aspects of the pursuit of justice.⁷⁹ These features of Anderson's fourth and fifth desideratum are also applicable to justice in health care, particularly the social dimensions I have discussed. Assuming Anderson's desiderata and building on her account of the point of egalitarianism, I propose that a relational approach to justice in health care is one that: *Expresses equal respect and concern for all citizens through the identification of certain health goods that are guaranteed for an entire lifetime and that offer appropriate remedies to socially indexed injustice without demeaning patients, while also allowing for the expression of collective willing.*

A relational approach to justice that fits this description allows liberal egalitarians to achieve a health-care system that is just across the various dimensions like those suggested by Deplazes-Zemp. Additionally, this relational approach would be compatible with the concepts of relational autonomy, social justice, and solidarity found in other relational approaches in bioethics. In short, this account of a relational approach addresses both the distributive and non-distributive dimensions of justice. As suggested earlier, the first and third desiderata allow liberal egalitarians to address the distributive dimension of justice while the other desiderata address the non-distributive dimensions of justice. A relational approach meeting this description addresses the distributive dimension of justice because it requires liberal egalitarians to guarantee health goods.

However, this relational approach also addresses non-distributive dimensions of justice primarily because of its focus on social relations. By focusing on social relations, liberal egalitarians can acknowledge the interconnectedness of persons explicit in the principles of relational autonomy and solidarity. This interconnectedness is partially constitutive of individuality and our meaning-making practices to such an extent that equal respect for persons cannot be expressed without accounting for it. Relationists relying on this approach are better situated to respond to interconnectedness while acknowledging that health-relevant features of justice

⁷⁹ A charitable reading of Daniels suggests that this element is present in his view that society bears responsibility in addressing the health needs of individuals. However, Daniels' view seems to be that the only role for social efforts is to ensure that individuals get to the point where they are individually responsible for their health (2008, 62).

are not restricted to explicitly health-focused contexts.

Given their reliance on the relational paradigm and the primary goal of ensuring that society treat all citizens with equal concern and regard in all health-relevant ways, the approach I am proposing has the following negative and positive aims. This approach's negative aim is to eliminate health-relevant social disadvantage, especially when this disadvantage results in health disparities between health groups. This negative aim stems from the fact that within a liberal framework, health care is a collective practice that cannot be justified unless its coercive features are distributed in a way that expresses equal respect for all citizens.

My relational approach's positive aim is to ensure that the pursuit of health is respectful and productive of lives that are expressive of individual and socio-cultural, which is to say group-based, value. This approach is meant to ensure that healthcare interventions are adequate for addressing individuals' health needs and the various social groups of which individuals are members. This positive aim stems from the recognition of the role that health statuses play in determining the individual and socially constituted lives that are the target of expressions of equal respect. In other words, there is a general recognition that the expression of equal respect requires attentiveness to the values that make lives meaningful. Distributivists like Ronald Dworkin seem to agree with this view. He argues that treating people as equals requires focusing on making their lives equally desirable to them (1981, 189). Of course, the exact way this positive aim will be achieved will be context-dependent and will require further extrapolation, but my goal here is to show that relational approaches can create the basis for such a positive aim.

These two aims are guided by both relational egalitarian commitments and the fact that, as I have argued so far, health is never merely an individual affair. Because health is never merely individual, equal respect for persons requires the recognition that sometimes the only way to help individuals is by attending to the social. A relational approach to justice in health care pursued with these aims in mind is well-suited to address the injustices that arise in health care, including in non-clinical health-care practices. To reiterate, what sets this approach apart from one embedded in the distributive paradigm is a commitment to the social dimensions of health relevant to the considerations of justice in health care, particularly when health groups are also taken to be appropriate units of concern.

I believe the relational approach to justice in health care just described is the best way to satisfy the liberal egalitarian goal of treating all citizens as equals because it is the best way to address all health-relevant injustices for all citizens. As I have tried to show, individuals are socially situated, particularly when it comes to

health. Additionally, there are health-relevant injustices affecting individuals that either occur in virtue of group membership or can only be redressed at the level of the group. Consequently, the expression of equal respect requires attentiveness to social and group-level dynamics in the way required in the relational approach to justice presented here.

As I argued in sections 1.3 and 1.4, we can understand the kinds of injustice that concern relationists in terms of social meaning and social status. Relationists worry that non-distributive factors such as discrimination, bias, and devaluation produce injustice beyond mere distributive considerations. Take, for example, the campaign against Jim Crow laws and their “separate but equal” policies during the civil rights movement of the nineteen sixties United States of America. Civil rights activists argued that the distributive equality ostensibly offered by these policies failed to amount to full equality for Black people (Cottrol, Diamond and Ware 2004). Importantly, the perniciousness of “separate but equal” is most evident when examining its group-level impact. Even if every individual child had been offered equal access to important social goods like health and education under segregationist Jim Crow policies, these policies were meant to preserve “white” spaces and protect white people from Black people. It exposes the inequality that the equal distribution could not address. Instead, what is evident is that equal distribution served to maintain and perpetuate problematic social meaning and status attached to race.⁸⁰

Of course, a legitimate case can also be made that Jim Crow segregation never achieved true distributive equality and instead exacerbated inequalities. This line of argument was behind the National Association for the Advancement of Colored People’s (NAACP) early legal strategies against Jim Crow laws (Cottrol, Diamond and Ware 2004). Evidence has also shown that the abolition of Jim Crow laws produced greater health equality in dimensions like childhood mortality (Krieger et al., 2013; Patterson, 2009). Findings like this suggest that segregation failed to secure distributive equality. But, as noted earlier, civil rights activists objected to Jim Crow segregation not merely because of its distributive failures but because it also maintained an entire group of people in a lower social status (Halberstam 1960). This line of argument became Apparent in *Sweatt v. Painter* (1950), where the NAACP successfully argued that segregation is inherently unequal even when it is consistent with equal distributions.

The fight against Jim Crow segregation contested the meaning of what it means to regard people as

⁸⁰ See also Shelby 2007 who focuses on how discriminatory practices, including Jim Crow segregation, were constitutive of non-distributive harms such as disvalue and disrespect of Black lives.

equals in a way that is directly relevant to the dispute between distributivists and relationists. The relationist position is driven by a belief that the expression of equal respect takes more than ensuring that individuals have equal distributions. I take this intuition to be consistent with accounts like that of Ronald Sundstrom, who suggests that the spaces we occupy are generally an important part of our self-conception.⁸¹ Sundstrom notes that racialized places, like those that are the legacy of Jim Crow or redlining,⁸² have distributive implications. However, he goes on to say that what is perhaps most central about these spaces is the effect they have on the “physical and mental health and other psychological aspects of the individual” (Sundstrom 2003, 91). This view suggests that Sundstrom takes it to be the case that it is not merely the distributive patterns of policies like Jim Crow that are problematic. It is also that they inevitably produce health-relevant harms.⁸³ This view is consistent with what I take to be the relationist position that the expression of equal respect involves justice-relevant concerns that persist even if distributive equality can be achieved.

Vaccine hesitancy is one example of how non-distributive justice-relevant concerns can affect a health care system (Cooper, et al. 2018; Quinn, et al. 2019). While Vaccine hesitancy can be caused by a lack of confidence in the vaccine, it can also be caused by distrust of health care providers (Armstrong, et al. 2006). In both cases, vaccine hesitancy can result in health-relevant injustice to the extent that it leads to avoidable harm. But whereas an argument can be made that lack of vaccine confidence can be addressed through the distribution of a good like health education or health literacy, it is less clear that there is a distribution that can directly address distrust. This distrust can also be a byproduct of social injustice, such as the Tuskegee Syphilis Study (Freimuth, et al. 2001; Durant, et al. 2011). Examples like these also point to how past injustice can cause lingering harms even after distributive correctives have been implemented. As Orlando Patterson (1997) and others have argued, distrust of this kind is ultimately a relational and social issue, and the expression of equal respect in light of this distrust is not merely a distributive matter.

Liberal egalitarians operating within an approach to justice committed to relational autonomy, social justice, and solidarity have the conceptual tools to diagnose what is problematic about social arrangements like Jim Crow segregation and the individualistic approach to health care. This problem can be summed up by saying

⁸¹ Think of the excitement of finding out someone is from your hometown regardless of any other shared connection.

⁸² Redlining is the practice of denying financial products to certain (predominantly members of non-White racial groups) to prevent them from owning property in certain neighborhoods.

⁸³ Although, it is worth noting that Sundstrom (2013) seems to allow that separate racialized spaces can avoid some of these harms if proper attention is paid to efforts like community building.

that the social has such a bearing on the individual such that some individuals and some aspects of individuality cannot be considered without accounting for and addressing the social. At the same time, these relational concepts provide liberals with the tools to start to correct these kinds of problems in a way that can direct and guide health care policy. Once we understand the extent to which individuals are socially situated, we can identify how best to address all aspects of their health.

4.6 Conclusion

Liberal egalitarians believe that the pursuit of justice is about expressing equal respect for citizens. One question emerging out of this belief concerns what it means to treat people as equals. Another question concerns how best to conceptualize the idea of a citizen such that liberal egalitarians can be successful in this pursuit. On the distributivist view, equal respect is expressed in terms of distributions, and citizens are individuals to whom these distributions are owed. On the relationist view, equality is expressed in egalitarian social relations such that distributions provide an insufficient basis for evaluating whether citizens are being afforded equal respect. More importantly, for relationists, citizens are always interconnected social beings such that the state cannot express equal respect for them without attending to the non-distributive social factors that are constitutive of identity.

The respects in which these approaches diverge matter because they have implications for whether and how liberal egalitarians pursue equal regard for citizens. I have argued that the distributivist view on this matter is ultimately inadequate for the expression of equal respect for citizens when it comes to health care. Given the social dimensions of health, inequality is not merely distributive, and injustice involves more than just the individual because patients are interconnected. I have tried to show that injustice within health care appears in non-distributive registers and can persist even if we achieve distributive equality. I have also tried to show that patients within a health care system are not merely individuals but are always socially situated and often connected to others in various health-relevant ways. If these two lines of argument are right, equal treatment cannot be exclusively satisfied with distributions, and the operative notion of citizens within the liberal egalitarian framework of health care justice cannot be entirely individualistic.

What my view strongly suggests, then, is that an approach to justice that focuses on distributions to individuals will fail to adequately address the justice-relevant needs of those who are more reliant on others and those whose needs go beyond distributive concerns. Furthermore, my view suggests that the wrongness of inequality in health care is not merely that some individuals lack some health-relevant good as some distributivists worry, nor is it merely that some might experience shame or humiliation as some relationists argue. Instead, the

wrongness of inequality in health care stems from how it results in avoidable harm to health that is bad for individuals and has adverse effects on our lives in light of our various group memberships. The relational approach I am defending aims to address this type of wrong directly. In doing so, it addresses the distributive and non-distributive factors that motivate liberal egalitarian commitments.

These features are consistent with the goals of relational approaches to justice. As stated earlier, relational approaches will have the negative aim of eliminating inequalitarian social relations and the positive aim of ensuring that all citizens are treated equally. These aims capture the responsibility of governments, as vehicles of collective willing, towards citizens, as interdependent, socially situated persons. Achieving these aims requires both distributive and non-distributive means. By focusing on relational autonomy, social justice, and solidarity, relationists can take an approach to justice in health care that is sensitive to the non-distributive and social dimensions of health. Consequently, relational approaches to justice are much more accommodating of health groups as appropriate units of concern and social, non-straightforwardly distributive interventions as appropriate mechanisms of redress.

Whether the issue is like that of health disparities resulting from Jim Crow segregation or the harmful effects of vaccine hesitancy, one cannot fully address the injustice by merely focusing on the individual. If we account for the social dimensions of health, we can recognize that equal treatment in these cases requires something like the relational paradigm and a focus on more than just the individual. Attention needs to be paid to both the interpersonal and group-level factors that result in injustice. Some individuals are more reliant on others, and all of us are vulnerable to health-relevant factors beyond our control. It is only by attending to these features of health that we can afford everyone equal treatment.

Chapter 5

Objections

5.1 Introduction

I have argued two main points in this dissertation. The first point is that liberal egalitarian principles of individual liberty, social justice, and equality are best captured by relational approaches to justice, particularly those framed in terms of the principles of relational autonomy and solidarity. Relational approaches allow liberal egalitarians to satisfy their distributive goals in the pursuit of justice just as well as they would if they relied on distributive approaches. But relational approaches outperform distributive approaches to justice in the liberal egalitarian pursuit of non-distributive goals. The second point I have argued is that the social dimensions of health also necessitate relational approaches to justice since these approaches are sensitive to how injustice is both socially caused and a feature of groups. Together, these two claims support the conclusion that liberal egalitarians ought to be relationists when it comes to justice in health care since relationism provides approaches that address the full array of justice-relevant concerns in a way that best expresses equal respect for all citizens.

In this chapter, I entertain a few key objections to highlight important features of my argument. The first group of objections focuses on aspects of my account that stem from general worries about relational approaches to justice. The second group of objections focuses on the specific approach presented in chapters three and four. While these objections pose important challenges to my account, I believe they can be sufficiently addressed in a way that still supports my thesis about the need for liberal egalitarians to be relationists about justice in health care.

My argument in this chapter proceeds as follows. In section 5.2, I revisit the debate between liberal egalitarians to examine general concerns about the nature of justice. These concerns focus on whether relational approaches accurately capture the concerns of justice and point to some potential shortcomings with relational approaches when it comes to addressing core liberal egalitarian commitments. In section 5.3, I explore three groups of concerns specific to my account of relational approaches and my claim that these approaches are better equipped to secure justice in health care given the social dimensions of health care. In section 5.4, I conclude with some reflections about the practical implications of liberal egalitarian theories of justice in health care and the dichotomy between distributive and relational approaches.

5.2 Objections Regarding the Nature of Justice

As stated throughout this dissertation, the debate between distributivists and relationists is ultimately about how the state best treats its citizens as equals. Despite some differences in its characterization, distributivists believe that the pursuit of justice is about distributions and is therefore concerned with distributive patterns. This focus on distributions can lead to a few objections worth exploring, given the account I have defended. One set of concerns regards the currency of justice. On this line of critique, relationists misconstrue the concerns of justice in one of two ways: either they fail to see what justice is about, or they fail to see how justice is achieved. These differing approaches allow two types of distributivists, those who only focus on distributions and those who are amenable to some aspects of the relational project.

Strict Distributivism

Strict distributivists might worry that relationists misconstrue the concerns of justice by failing to see that the pursuit of justice should focus only on distributive patterns since justice is only about distributions. On this view, while non-distributive factors and states of affairs might be normatively salient on other registers, they are not justice relevant. Relational ideals are thus either part of a non-justice moral register or are otherwise laudable but not mandatory.

However, there are at least two ways in which a strictly distributive conception of justice is unwarranted. First, distributive patterns are often intertwined with non-distributive considerations. As I argued in chapter 3, distributive patterns are determined by non-distributive factors such as value commitments. For example, luck egalitarians pursue distributive interventions based on the value of individual choice (e.g., Miller 2017; Segall 2010; Gheaus 2016). However, commitments to other values like guarantees of universal decent minimums have led other distributivists to defend competing distributive approaches to justice (e.g., Buchanan 1984). In other words, even if justice is concerned with distributive patterns, there are non-distributive considerations that must be weighed to determine those distributive patterns.

This point is perhaps clarified in considering a key premise of Richard Thaler and Cass Sunstein's argument in *Nudge* (2008). Thaler and Sunstein argue that human choice is never made in a vacuum and the design of the environment in which choices are made inevitably has a bearing on those choices and how they are made. Thaler and Sunstein maintain that this is true even if the choices are unaltered. Based on this idea, Thaler and Sunstein argue that those designing these choice environments ought to "nudge" choices in the direction that is in the chooser's best interest, a strategy they term "libertarian paternalism." If Thaler and Sunstein are right,

distributive patterns are contingent on how we have designed the environments in which they appear. In other words, non-distributive considerations are antecedent to the manifestation of distributive patterns such that non-distributive factors should be attended to, even if the focus is on distributions. But, as I have argued through this dissertation, the relational paradigm is better equipped to guide these non-distributive considerations in a way that best satisfies liberal egalitarian commitments.

Another problem with the idea that justice is only about distributions is that distributive patterns can have non-distributive implications relevant to justice. As I suggested in chapters 2 and 3, certain distributive patterns exacerbate existing inequalities by privileging the lived experiences of citizens with only some forms of embodiment. The choice/luck distinction adopted by luck egalitarians is meant to address the kind of disadvantage that stems from this kind of inequality when it is unchosen. Nonetheless, in acknowledging this kind of disadvantage, luck egalitarians must accept that justice-relevant concerns are not strictly distributive. As a result, the strict distributivist position seems untenable.

Of course, distributivists might be right that justice is ultimately about distributions. If that is the case, then there are at least two possibilities, one that I find acceptable and one that I find objectionable. The acceptable possibility is that the social dimensions of health discussed in this dissertation could be addressed within other moral registers. For example, there is still a non-justice moral framework under which relational harms within the doctor-patient relationship can be addressed. I believe we still need to think about addressing these kinds of harms in our pursuit of justice, but I see no need to insist that these are injustices if alternative frameworks redress the harms. Someone like Daniels seems amenable to this position since he acknowledges that there are non-distributive moral harms within health care.

On the other hand, the objectionable possibility is that there could be significant moral harms that are not redressed because they are beyond the scope of justice. This will be the case if it turns out that some relational harms cannot be addressed through either distributions or non-collective moral interventions. Some people's refusal to wear masks during the COVID-19 pandemic could be a good example of this kind of harm. Without some sort of collective sanction, I might be very limited in my ability to protect myself from an infected non-masker. If distributivists are right and these kinds of scenarios are not justice relevant, then that is a misfortune that could quickly border on the tragic.

Compatibilist Distributivism

Alternatively, distributivists can view either the conclusion or methodology of relationism as compatible

with distributivism while concluding that distributive patterns ultimately prevail. For instance, a distributivist can accept the relationist claim that our pursuit of justice should secure egalitarian social relations while maintaining that this can only be achieved through distributive means.⁸⁴ This position also stems from the belief that demands for justice only occur under conditions of moderate scarcity. On this view, even if justice is ultimately about securing egalitarian social relations, the way to achieve this goal is to address moderate scarcity through distributive means. Additionally, distributivists holding this position might maintain that only distributive interventions are at the state's disposal. For instance, it seems easier to design distributive strategies for health care than to identify and address non-distributive concerns. As a result, the state might need to focus on distributive concerns for pragmatic reasons.

Alternatively, distributivists who are compatibilists about the nature of justice could argue that the ideals pursued in relational approaches are ultimately instrumental to addressing some underlying distributive problems. For example, strict distributivists might acknowledge that physician implicit bias is a real relational problem that produces inequalities like disproportionate racial health disparities. However, they could still contend that this issue is problematic not because of any relational harm but because it causes a deficit of distributions such as effective access to care.

Similarly, distributivists might object that a commitment to distributivism does not entail a commitment to either the distributive paradigm or distributive interventions, as I have suggested. Distributivist might accept that our pursuit of justice sometimes requires us to attend to relational or group-based concerns. However, they would contend that the justification for the relational approach is ultimately a distributive ideal. Brian Berkey (2018) defends such a view in arguing that the pursuit of justice should be expressive of egalitarian social relations but is best understood as grounded in a commitment to providing all citizens with a sufficient level of some health-relevant good.

I have a few responses to these kinds of worries. First, these objections are largely consistent with my account. On the one hand, distributivists would be accepting the core claim that liberal egalitarians ought to be relationists since a key concession of the relationist view is that distributions are sometimes necessary to meet the demands of justice. As I argued in chapter 4, the relational paradigm acknowledges that there are distributive dimensions to justice. Several distributivists acknowledge that relational considerations are germane to the pursuit of justice (e.g., Knight 2015 and Gheaus 2016). Once this concession is made, these positions are no longer

⁸⁴ e.g., Ruger 2007

strictly distributivist and look more like relational accounts on my interpretation.

I would reiterate that distributions still matter within the relational paradigm. As a result, relational approaches can accommodate distributions to secure a more just state of affairs. However, the relational paradigm requires liberal egalitarians to go one step further and ask whether these distributions improve the lived condition and social standing of those experiencing the target injustice. To the extent that distributive approaches take this extra step, they are consistent with this relational paradigm. But again, they no longer seem to advance an approach to justice that is primarily concerned with distributive patterns.

My second response echoes what I have already said. Even if we accept that the state only has distributive interventions at its disposal, there still needs to be some second-order management of these distributions. This second-order management does not seem to be straightforwardly distributive. The continued attempt to repeal the Affordable Care Act by the administration of former US President Donald Trump provides a good example. While these efforts focused on distributions of health care insurance and the resources necessary to make the insurance scheme operational, this distributive intervention was guided by Trump's ideological commitment to tax cuts (Hanlon, Vinelli and Weller 2020). Similarly, the Affordable Care Act was designed to satisfy ideological commitments to goals like coverage for pre-existing health conditions (Emanuel 2018). This example demonstrates how distributive patterns are the result of commitments that are not themselves strictly distributive.

That said, I am resistant to reframing all approaches to justice in terms of their distributive implications. For instance, it is not clear that any kind of distribution is operative in the social stigma surrounding a condition like schizophrenia. When conditions like schizophrenia are stigmatized, I do not believe that the injustice that results is a problem in distribution patterns. Some distributivist might argue that these cases involve problematic distributions of non-material goods such as esteem. However, I worry that these kinds of responses overextend the notion of distribution. Distributions are involved in other cases like the vaccination schemes discussed in chapter 4. But the justness of those schemes cannot be evaluated simply by looking at distributive patterns since benefits and burdens are separable. This scenario strikes me as a significant departure from the standard conceptualization of distributions within distributive approaches. These two examples suggest that questions of justice are not always reducible to distributive patterns, which brings us back to needing something like a relational paradigm to fully capture what it is that we are attempting to accomplish in the pursuit of justice in health care.

5.3 Specific Objections to My Account of Justice in Health Care

In addition to general concerns about relational approaches, some objections are more directly tied to my argument, particularly related to justice in health care. In this section, I entertain objections that fall into four categories. The first category involves concerns about whether my account provides the best conceptualization of health for thinking about justice. The second category involves concerns about how I have characterized the relationship between individuals and distributions. The third category involves concerns about the separateness of individuals. The final category involves concerns about whether relational approaches can be self-defeating.

Conceptualizing Health

One worry might be whether the account of health I have advanced provides the best lens through which to consider questions of justice in health care. For instance, one could worry that my account might not allow us to properly ground our obligations of justice when health conditions are not indexed to egalitarian social relations. Berkey's example of someone who suffers from chronic pain that adversely impacts her quality of life without any social implication is an attempt to provide just such a scenario.⁸⁵ This example is meant to show that the distributive paradigm, with its individual and clinical focus, is simply better equipped to address some questions of justice, given that the relational paradigm frames justice in terms of social relations.

I acknowledge that the mere fact of treating members of a society as equals is not going to obviate underlying physiological or pathological facts as Berkey's example is meant to suggest. Lia Lee's case in Anne Fadiman's *The Spirit Catches You and You Fall Down* (1997) is also illustrative. In this case, conflict arises between competing interpretations of Lia's "epileptic" condition offered by the Hmong versus Western-biomedical explanatory frameworks. As this conflict suggests, underlying physiological facts are often not in dispute, even though disagreement can ensue about what those facts mean. Lia's family, adhering to the Hmong framework, took Lia's condition to be a divine blessing requiring appreciation. Meanwhile, Lia's doctors, adhering to the Western-biomedical framework, took her condition to be an adverse medical condition requiring treatment. Since it was accepted that Lia had certain experiences, there was perhaps a way to pursue the alleviation of Lia's suffering in a way that was compatible with treating her condition as a social privilege.

My point is that the relational paradigm does not ask us to ignore underlying physiological conditions and

⁸⁵ Alternatively, one might worry that an implication of my account is that it might be preferable to allow certain health conditions to remain unaddressed for the sake of preserving egalitarian social relations when there are scarce resources. While objections like these are entertained in the broader liberal egalitarian literature, they have not gained much traction in the literature on justice in health care so I will not address them here.

their suffering. To paraphrase Elizabeth Barnes (2017), it is important to recognize that some conditions, like chronic pain and certain disabilities, suck, are bad and genuinely constitute suffering that should be alleviated. However, the relational paradigm asks us to go beyond this alleviation and eliminate any inegalitarian social relations that lead to that suffering. This position does not entail that inegalitarian social relations are the only relevant considerations in pursuing health care justice, only that they should be redressed when they are present.

Barnes contends that factors such as social support, disability group identity, and social acceptance have a greater impact on people's relationship with their physiological conditions than the severity of those conditions. In other words, regardless of their physiological condition, people's experience of health is significantly influenced by social factors. While I have highlighted the various social dimensions of health in previous chapters, Barnes' claim and the example of Lia Lee help to show that the social dimensions of health stem from the fact that health is at least in part socially determined and socially situated.

This is the sense in which I have argued that health is socially indexed. It means that health not only occurs in and can be impacted by social contexts but can also be interpreted differently depending on those contexts. To say that health is socially constructed suggests that the conditions of health and illness are often imbued with social meaning that is non-totalizing, malleable, and negotiable. While Lia's case is particularly stark because of the radical divergence of the competing worldviews, it highlights a more general idea that health is not simply about physiological or pathological facts. To reiterate, in Lia's case, the disagreement is about what those facts mean and how they should be addressed, not about whether they exist. Similarly, Barnes' examples show that considerations of health are not merely about certain physiological conditions and how to treat those conditions, but also how we treat the people with those conditions in our various social arrangements.

However, I would also acknowledge that physiological conditions often have social implications. People with the kind of chronic pain discussed in Berkey's example are often unable to participate in many aspects of social life or must do so in ways that are either limited or emotionally, physically, or financially costly. These costs are considered unjust under a relational paradigm not merely because they might result in explicit differential treatment. Instead, the relational view is that it is unjust that society is structured to force people with some physiological conditions to bear costs that those with other physiological conditions can avoid. Again, this critique is most salient within democratic societies where social structures are supposed to be embodiments of the will of the collective.

On the Individual, Distributions, and the Due Respect for Persons

Another worry might be that my account fails to adequately address the reason for the apparent preference for distributive approaches to justice in health care among liberal egalitarians. If relational approaches are indeed as preferable as I have argued, we might expect relational approaches to justice in health care to be more prevalent. The dearth of relational approaches to justice in health care would thus suggest that they are somehow inadequate. Similarly, one might wonder whether there is a way of framing the distributive paradigm to address the primary goals of health care. In other words, the mere fact that there are clinical and non-clinical segments of health care does not entail that each segment has significantly different goals. After all, the beneficiaries of clinical and non-clinical care and the constitutive members of groups and societies are ultimately individuals. There is also a related concern that my argument against the distributive paradigm could be question-begging. I characterize the distributive paradigm as having an individual focus then state that it has trouble accounting for justice-relevant considerations beyond individuals. But it should not be surprising that a paradigm of justice that has an individual focus cannot account for cases beyond the individual.⁸⁶

However, as I have argued, the distributive paradigm is so entrenched in Western-style biomedicine that there is a presumption towards a distributive conception of health even in cases where other frameworks might be more appropriate. This presumption leads to another presumption that justice in health care must also be distributive. As I concede in chapter 3, this presumption makes sense to a certain extent. The distributive paradigm allows a healthcare system to meet goals like adequate patient care in part because these goals require us to address the health needs of individual patients. This segment of health care is indeed justice relevant, but just as clinical care does not exhaust all aspects of health and health care, justice in health care is not exhausted by the injustices that are only registered within this context.

As I argued in chapter 4, non-liberal approaches to bioethics reflect a growing recognition of the distributive paradigm's limitations. Liberal egalitarians have been slow to adopt a different paradigm in part because of the distributive paradigm's usefulness and their commitment to individual rights. But I have tried to show that fully satisfying this commitment requires recognizing the individual's social context. To reiterate, even if our focus is on the individual, I believe that the rights of some individuals cannot be adequately addressed without attending to social relations, including their membership in justice relevant groups. In this respect, the relational paradigm offers an alternative to the impoverished view of individual concerns provided by the

⁸⁶ Thanks to Matthew Congdon for this objection.

distributive paradigm. In other words, I do not believe that we can adequately address the concern of individuals without also attending to the concerns of the groups of which they are a part. Furthermore, health care involves more stakeholders than just the individual recipient of care in the same way that health itself can be a feature that extends to entities other than the individual. Consequently, something like the relational paradigm is necessary to better capture all the justice-relevant concerns of health care.

In many respects, these objections get at the liberal commitment to individuals. When there is a plurality of persons in a context of scarce resources, their claims to justice can conflict. In such a context, Rawls suggests that fairness requires us to treat these individuals as separate, which would allow them to be afforded equal consideration as moral persons (1999, 166-167). This idea is so strong that many relationists also focus on the individual as the primary, if not the only, unit of moral concern. For instance, while Elizabeth Anderson (1999) is sensitive to how oppression is indexed to group membership, her concern is how this results in injustice for individuals.

However, I have tried to show that we cannot provide a full account of individuals without accounting for their sociality. In my native Shona culture, this idea is expressed in the notion that there is no personal identity without group membership. For example, the Shona people generally do not address people, especially adults, simply by their given names. Instead, people are addressed by their family relations. My mother is referred to as "Mai Takunda" (mother of Takunda) or some other relational name that indicates her familial connection to the person addressing her. The importance of group membership in this context is also expressed in asking two key pieces of information when the Shona meet. The Shona people ask for a person's familial hometown and their totem or family animal. These questions help reveal how someone is connected to the family they already know and how they might be family with the stranger they are meeting for the first time.

While these social practices might seem strange within a Western context, they provide insight into some key ideas of my account. Individuals are interconnected in ways that are inextricable from the structures of care necessary for their individuality. While some of these connections might not be apparent to us, they are nonetheless real and consequential. As I argued in chapter 4, no individual makes it through life without relying on others, particularly through relations of care when we are at our most vulnerable or ill. Some individuals are so reliant on those relations that the only way to address their needs is to address the relations. A clarification of Rawls' view helps to emphasize this point. The separateness of persons should be respected only to the extent that it allows for the equal consideration of moral persons. But when separateness entails isolation and abandonment,

individuality is not the best way to treat someone as a moral equal.

In other words, we sometimes, maybe even frequently, are best served by attending to our interconnectedness rather than separateness in order to ensure that everyone is treated as moral equals. As I have argued, there is a moral imperative to take the idea of groups as units of moral concern seriously. As Madison Powers and Ruth Faden argue, "Some who fare worse than others, often in multiple respects, are members of groups who are socially situated within densely woven patterns of disadvantage" (2006, 18). For these individuals, justice cannot obtain without addressing the disadvantage faced by the groups of which they are members. Public health practice is premised on this idea, suggesting that our pursuit of justice in health care must also recognize social relations and groups as relevant units of moral concern.

Relationism as Self-Defeating

The last worry I will address is that egalitarian social relations could be consistent with problematic states of affairs, including inegalitarian social relations, and is therefore self-defeating. For instance, a growing body of literature explores how non-distributive interventions can improve health behavior around smoking, alcohol consumption, diet, and physical activity.⁸⁷ This literature explores Thaler and Sunstein's theory that distributive patterns can be significantly altered simply by modifying the context and manner of decision-making. One prominent example is the research showing that simply changing the default option for organ donation from opt-in to opt-out almost doubles the percentage of people who become organ donors.⁸⁸ But critics have raised concerns about whether these types of interventions involve problematic actions like shaming, stigmatization, manipulation, and strong paternalism.⁸⁹

Jan Schnellenbach (2011) takes this worry further and argues that non-distributive interventions like nudging are susceptible to the adverse effects of biases and cognitive deficiencies to such an extent that they can perpetuate problematic existing social norms. Schnellenbach worries that interventions like nudging involve the state deciding what is in an individual's best interest in cases where individuals are better situated to evaluate their own needs. For example, changing the default for organ donation could violate cultural norms and practices around funerary rights. To put it differently, there is a worry that the kinds of non-distributive interventions that might be defended under a relational paradigm could perpetuate or exacerbate the inegalitarian social relations

⁸⁷ See for example, Sunstein 2015 and Marteau et al. 2011.

⁸⁸ See, for example, Johnson and Goldstein 2003 and Steffel, Williams and Tannenbaum 2019.

⁸⁹ See, for example, e.g., Wilkinson 2013, Eyal 2014, and Voigt 2014.

they are meant to eliminate.

These kinds of objections present perhaps the strongest challenge to relational approaches since they highlight how these approaches can be self-defeating. Nonetheless, these kinds of objections do not provide enough grounds for abandoning relational approaches. The relational paradigm might not provide a mechanism to head off these worries completely, but I also do not see these worries presenting anything in favor of distributivism. Instead, these objections emphasize an important commitment of the relational paradigm and provide insight into Thaler and Sunstein's conception of nudging.

As I have argued in this chapter and chapter 3, both the relational paradigm and libertarian paternalism are premised on the idea that there are no value-neutral contexts for distributive patterns and individual choice. If I am right, the relational paradigm can accommodate critiques of the values and commitments that bring about or maintain certain social arrangements, including arrangements stemming from relational approaches. Additionally, the relational paradigm allows relationists to be sensitive to how chosen interventions present value conflict. So, while relational approaches could perpetuate or exacerbate inequalitarian social relations, they are also best equipped to register those social relations as inequalitarian and are better situated to accurately diagnose their causes. In contrast, concerns like those raised by Schnellenbach and others might not be recognized as legitimate within a distributive paradigm. As a result, distributivists do not often worry about whether certain distributive patterns produce avoidable stigma or shame. The relational paradigm at least requires its adherents to recognize these failures as injustices and pursue their remedies.

5.4 Conclusion

I want to conclude with some final remarks on what is at stake in adjudicating the debate between distributivists and relationists regarding justice in health care. As stated in the introduction, my interest in the issues explored in this dissertation began with a concern about the disproportionate racial health disparities experienced by Black mothers. I was struck by how these disparities persisted across socio-economic strata to such an extent that they did not seem to stem from the sorts of distributive deficiencies that have often been the focus of accounts of justice in health care. Reflection on these disparities led me to hypothesize that some injustices result from relational inequalities and not distributive inefficiencies. Any good hypothesis needs to be tested, clearly articulated, and adequately motivated. This dissertation is an attempt to articulate and motivate that hypothesis.

Despite evidence supporting the account I have defended in this dissertation, health is often treated as a

singular feature of individuals and not a complex, thick concept that is sometimes interpersonal. This is an oversight that leads to moral and policy errors when we shift towards health-relevant moral problems like racial health disparities that are only registered at the group-level or in non-clinical contexts. In cases like these, the distributive paradigm inappropriately prescribes individualistic solutions to problems that occur and must be addressed at the level of groups. Similarly, the failure to recognize the interpersonal nature of health can lead to a failure to register the moral demands generated by groups.

However, I chose not to focus on racial health disparities because doing so can misleadingly suggest that these concerns are only relevant to subjugated groups. Pandemics and epidemics show that this dissertation's concerns are germane to entire health care systems and all health populations. The COVID-19 pandemic is a good example of how a strictly individualistic and distributive framework is inadequate for understanding health and justice-relevant considerations in health care. Some concerns generated by this pandemic have certainly involved clinical matters involving treatment regimens for severely sick individuals. However, other concerns have also been generated around social and non-clinical matters like social distancing, economic shutdowns, disease prevalence, and health outcomes as features of health populations. These are matters that have affected every kind of individual, social group, and the state.

Public health emergencies like the COVID-19 pandemic also highlight the central role governments play in providing just healthcare systems for all citizens. Unlike diseases and infections, which affect individuals, or a small number of people, epidemics and pandemics make patients out of entire populations. As a result, epidemics and pandemics necessitate care relationships that are broader than standard clinical relationships. Because governments are concerned with health populations and generalized and aggregated individuals, they are the key duty-holders for addressing these kinds of public health emergencies. However, as the various efforts to institute mask mandates, stay-at-home orders, and economic shutdowns show, governments have duties towards both the sick and the healthy. In contexts like these, the satisfaction of some duties occasionally results in failures to satisfy others, resulting in far-reaching consequences for social arrangements.

The COVID-19 pandemic also highlights one of the biggest gaps left unaddressed by the account presented here. Unlike epidemics, which, in theory, are isolated within a singular nation-state, pandemics are global phenomena. The liberal framework provides a straightforward way to think about the responsibility of the state to its citizens. Nevertheless, there is disagreement among liberals about whether their framework is helpful for thinking about these questions at the global or inter-governmental level. While pandemics are contexts in

which various moral demands are generated, the status of right and duty holders is murkier due to a lack of clearly delineated relationships that can be the grounds for the generation of obligations.

While resolving the exact nature of these obligations is beyond the scope of what I have aimed to do, such a project is justifiable within a relational paradigm. The broader point is that the adequate response to public health emergencies like the COVID-19 pandemic requires health care systems in which we are attentive to health-relevant factors that go beyond the individual patient in a clinical setting. These health care systems are not structured in a vacuum. Instead, they are shaped by health care policy, which is shaped by frameworks of justice. Consequently, we need frameworks of justice that are also sensitive to the kinds of issues that will challenge these systems. I have argued that the relational paradigm provides the requisite kind of framework. Failure to rely on an adequate framework has the potential to perpetuate social disadvantage, a consequence that is particularly pernicious given the state's role as a vehicle for collective willing. In these cases, the state disadvantages some of the very people who empower it and are meant to be beneficiaries of its coercive power. To prevent this type of failure, societies need a framework of justice that is responsive to distributive and non-distributive considerations. My view is that the relational paradigm and its relational approaches allow liberal egalitarians to achieve this goal. The relational paradigm equips liberal egalitarians with a framework for diagnosing the full array of justice-relevant harms and properly prescribing solutions to these harms. Such a framework would ensure that the health care system meets individual health needs while also ensuring that citizens stand in relations of equality.

As the preceding exploration has shown, there are many respects in which distributive and relational approaches are ultimately consistent with one another. Given their shared commitments, this should not be a surprising outcome. That said, as some of the objections entertained in this chapter show, not only are there situations where these approaches are both viable, there also may be contexts in which neither approach is adequate. This possibility suggests that there might be room for yet another approach to justice, perhaps something like the capabilities approach. Regardless of the approach taken, my broader claim is that our pursuit of justice in health care ought to address all relevant injustices. I believe that relational approaches tend to do the best job of achieving this goal within a liberal egalitarian framework.

Of course, the account presented here is just one aspect of thinking about how best to theorize justice within a health care system. Additional work needs to be done to figure out what the policy implications are. Work also needs to be done to identify workable non-distributive interventions that can apply to various contexts explored in this dissertation and other places. Strategies like nudging are useful starting points, but they are better

suited for problems like resistance to mask mandates than maternal health disparities. My objective with this dissertation was not to attempt to resolve all these problems but to motivate further exploration.

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