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RICE UNIVERSITY

SOCIAL JUSTICE IN HEALTH CARE: A CRITICAL APPRAISAL

by

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ABSTRACT

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by

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This work offers a philosophical appraisal of accounts of social justice in health care. By analyzing and comparing seven different accounts, it shows what is involved in advancing such an account and discloses what is involved in providing a moral justification, identifying a tripartite interplay among moral accounts, theories, and perspectives regarding the proper allocation of health care. Based on a distinction between substantive and procedural accounts of justice in health care allocation, it concludes that the prospect of agreement regarding substantive accounts of health care justice is unlikely.

This study illustrates that it is moral perspectives, rather than moral theories, that are foundational to accounts of justice in health care. A moral perspective includes the complete content of a morality lived by a group of people, while a moral theory identifies general statements formulateable within a moral perspective, a moral account restructures in a systematic way a moral perspective regarding a domain of issues, such as that of justice in health care. Although a moral theory contributes to an account a general framework that arranges moral commitments into a discursive system, only a full-bodied moral perspective can provide a moral account the substance that it needs. Through
closely looking at various moral perspectives embodied by different accounts of just health care, it becomes clear that disagreements in morality are extensive and deep. It is impossible to justify a particular substantive account of just health care without begging the question.

Finally, a theoretical reconstruction of Singapore’s Confucian moral perspective regarding health care justice is provided so as to offer a picture of a quite different theoretical foundation as well as a substantively different moral perspective from those that are often taken for granted in the West. It shows that moral perspectives are different from people to people, from community to community. A successful account of just health care will thus require more than what can be drawn from theories of justice.
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Chapter One

INTRODUCTION

Health care touches everyone. It involves the matter of life, suffering, and death. Its importance appears to be noticed by all individuals, families, communities, and governments. However, recent years have witnessed controversies regarding health care in nearly every area of the world, both industrialized and underdeveloped. Such problems often involve health care financing and allocation. Advancing technologies and aging populations have driven health care costs skyward. At the same time, many people do not have minimal medical insurance. As a result, debates regarding social justice in health care are increasing: how should society seek a just basis for allocating resources to health care? The question then becomes determining what should count as a just pattern of health care allocation. There in fact is no shortage of answers to this question. A plethora of accounts of just health care, more or less different from one to another, are already available in the literature. Scholars are concerned about justification of these accounts. It is assumed that an account of just health care must be justified in order to be applied with coercive state force. Consequently, arguments concerning justification have been integrated into each account of social justice in health care.

This work offers a philosophical appraisal of accounts of social justice in health care. By displaying and comparing seven different accounts, it shows what is involved in advancing such an account and discloses what is involved in providing a justification. In particular, this work identifies a tripartite interplay among moral accounts, theories, and perspectives of the proper allocation of health care. It offers a philosophical
reconstruction of various approaches to the morality of health care allocation. This study is not devoid of concrete moral implications for the just pattern of health care allocation.

To begin, this study finds an account of social justice in health care that is dominant in the sense that most essays addressing the issue belong to this type. Specifically, accounts of this type build their arguments around a principle of equality or a doctrine of rights formulated in a normative moral theory. Although such accounts disagree with each other regarding as to which moral theory as well as to which principle or doctrine ought to be appealed, each begins with a content-full substantive understanding of social justice and attempts to offer justification for its understanding. Thus, I term such accounts substantive accounts. Substantive accounts compass both a moral theory as well as content-full moral understanding in a justification of health care policy.

For the sake of comparison, I address these accounts in two chapters. Chapter Two explores three representative accounts based on principles of equality: Robert Veatch’s egalitarian account, Norman Daniels’ contractarian account, and Peter Singer’s utilitarian account. The moral core of each of these accounts is a particular principle of equality: the principle of equal objective net welfare for Veatch, the principle of fair equality of opportunity for Daniels, and the principle of equal consideration of interests for Singer. These accounts lead to more or less similar forms of state-controlled health care allocation. This chapter compares these accounts with respect to their principles, the theoretical bases of the principles and their concrete requirements, their measurement of equality, and their conclusions regarding health care allocation. It shows that all fail to offer persuasive arguments for their accounts.
Chapter Three examines three more substantive accounts: David Friedman's economic account, Charles Fried's deontological account, and Tom Beauchamp and James Childress' mid-level-principle account. The moral core of each of these accounts is a particular doctrine of rights: a doctrine of negative rights for Friedman, a doctrine of a general positive right for Fried, and a doctrine of a right to a decent minimum of health care for Beauchamp and Childress. These accounts produce substantively different conclusions regarding the issue of just health care allocation. This chapter compares the theoretical foundations and assumptions of these accounts. It demonstrates that the major arguments offered in these accounts are seriously defective. They cannot justify the conclusions they attempt to draw regarding just distribution of health care.

In contrast with these substantive accounts, H. Tristram Engelhardt, Jr. provides another type of account that is not based on substantive moral premises. Engelhardt argues that it is impossible to justify a particular content-full understanding of social justice without begging the question of moral content. Unlike the substantive accounts that offer a "substantive-premises-based" argument, Engelhardt's primary argument is for a procedure accepted by default. Given moral pluralism and the inability by sound rational argument to resolve controversies among different accounts of morality so as to establish one moral understanding as canonical, moral authority for common action must be drawn from consent. This shifts focus to acquiring permission for common undertakings. Accordingly, I term his account a procedural account. Under this account, since health care allocation is a joint human action, it must be governed by the principle of permission for gaining its moral authority. The state has no moral authority to impose a single-tier welfare health care program on everyone so as to develop a
particular substantive understanding of social justice. Chapter Four analyzes this procedural account and shows that this account requires a philosophical explanation of involvement in order to draw boundaries and establish side constraints.

How can it be the case that substantive accounts of just health care, although failing to offer convincing argument for their moral claims, remain the dominant accounts in contemporary Western societies? Chapter Five argues that this can be explained in terms of the intellectual focus on normative moral theories, rather than on what I term moral perspectives, namely, the detailed substance of morality lived by people. Focus on normative moral theories leads to the overlooking of the diversity and plurality of real moral commitments and convictions. Since normative moral theories support general moral principles or doctrines which are abstract, vague, and ambiguous, they can easily obtain the support of the intuitions of some individuals, ignoring the fact that there are a great number of such principles and doctrines which are often in conflict with each other and supported by contrary intuitions. Moreover, focusing on normative moral theories generates the impression that concrete moral conclusions are derived directly from normative moral theories and are thereby justified. Indeed, even the structure of the presentation in the previous chapters of this work may suggest that those substantive accounts of health care justice are derived directly from different moral theories, such as Veatch’s egalitarian theory, Daniels’ contractarian theory, Singer’s utilitarian theory, Friedman’s economic theory, Fried’s deontological theory, Beachampt and Childress’ mid-level-principle theory, and Engelhardt’s postmodern theory. It may also generate the impression that different types of moral theories lead to different accounts of just health care, while similar moral theories give rise to similar patterns of
health care allocation. It might be thought, for example, that all utilitarians support more or less similar modes of health care distribution, while all deontologists agree concerning their understandings of just health care. Finally, there might then be the conclusion that the view of social justice in health care one endorses is determined by the normative moral theory one accepts. This is not the case.

Chapter Five argues that the missing of the notion of a moral perspective accounts for such false impressions. Real moral explorations regarding social justice in health care involve complicated interactions among moral perspectives, theories, and accounts where a moral perspective includes full content of a morality lived by a group of people. A moral perspective is most inclusive in interpreting all major matters involved in a domain of moral concern, and need not be entirely discursive. On the other hand, a moral theory identifies general statements formulateable within a moral perspective. It is both general and systematic, compassing formal generalizations which turn out to be vague, ambiguous, and underdetermined without further interpretation. Finally, a moral account restructures in a systematic way a moral perspective regarding a domain of issues. It is a well-organized moral approach including both general principles, observations, and specific conclusions. What is important, a moral account cannot be derived from any one moral theory. It is rather a systematic reconstruction of a moral perspective regarding a domain of issues, such as that of social justice in health care. A normative moral theory contributes to an account a general framework that arranges moral commitments into a discursive system. Only a full-bodied moral perspective can provide a moral account the substance that it needs.
Specifically, a moral perspective compasses particular moral exemplars which consist of (1) interpretations of formal generalizations formulateable in the perspective (including the specifying, ranking, and balancing of goods and principles), (2) concrete problem-solutions and/or paradigm case-analyses, and (3) specific moral commitments. Different moral perspectives may share the same formal generalizations or moral theory but remain different moral perspectives, because they hold different particular moral exemplars. For example, although Friedman’s and Singer’s accounts are both committed to the utilitarian theory, Friedman’s supports a free market distribution of health care, while Singer’s argues for an entirely state-controlled health care system. Although Veatch’s and Daniels’ accounts are both based on contractarian theories, Daniels’ requires justice to be realized in society as the first priority, while Veatch’s holds that the requirement of justice is only one of a set of equally binding principles. On the other hand, even if two ethicists use different formal generalizations or moral theories, they may still hold the same moral perspective if they share the same specific moral commitments and offer similar interpretations for their respective formal generalizations as well as appeal to similar concrete problem-solutions and/or paradigm case-analyses. For example, although Beauchamp is a utilitarian and Childress a deontologist, they have come to the same set of moral principles and together argue for a right to a decent minimum of health care.

Chapter Five shows why the prospect of agreement regarding substantive accounts of health care justice is dim. Looking at the formal principles that people accept, the ways in which they specify, rank, and balance such principles, their particular moral commitments, and their concrete problem-solutions and case-analyses, let alone their
metaethical beliefs, it is clear that disagreements in morality are extensive and deep. This is a function of people living within different moral perspectives. Only Engelhardt's procedural account provides a way out. Although according to the definition of moral account used in this study, I should not even term his approach a moral account, because his is not a conceptual reconstruction of any particular moral perspective regarding justice in health care. The credibility of his procedural principle lies not in what one can establish through rational philosophical argument, but in what one can with moral authority justify even if one cannot justify any substantive moral claim as universally applicable.

In order to develop further the role of moral perspectives in shaping understandings of social justice in health care, Chapter Six turns to an examination of the Singapore health care system. It provides a theoretical reconstruction of Singapore's particular moral perspective regarding health care justice. Just as each of the theorists with substantive accounts under discussion has developed a conceptual reconstruction of a particular moral perspective to bolster its moral credibility, a reconstruction of the moral perspective of Singapore is provided so as to offer an account of the moral rationality that guides the soft authoritarian capitalistic public policy of Singapore. In particular, Chapter Six introduces Singapore's 1984 health care reform by underlying the principles that guided the reform. By comparing the Singaporean principles with the principles underlying the Clinton health plan in 1993, (1) the role of the moral perspective of contemporary Western egalitarian liberalism in the formulation of the American principles is set into relief, while (2) the moral perspective of the Confucian tradition is shown to underlie the Singaporean principles. The major difference between
the two moral perspectives are examined with special focus on how one seeks equality, while the other pursues harmony. This difference explains why the Clinton reform plan generated an essentially government-responsibility model of health care, while the Singaporean reform successfully led to a family-accountability model of health services.

What this chapter offers is not simply a display of a non-Western approach to social justice in health care, but also a further analysis of the role of moral perspectives in giving full substance to an account of social justice in health care. The analysis of the Singapore approach to health care policy offers a picture of a quite different theoretical foundation, as well as a substantively different moral perspective from those that are often taken for granted in the West. The heuristic of this contrast is advanced as a means for giving a further assessing the interplay among theory, account, and perspective. All of this indicates that it is moral perspectives rather than systematic moral theories that are foundational to accounts of social justice in health care. Moral perspectives are different from people to people, from community to community. They are lived, rather than organized. They are implicit in every aspect of moral life, health care included. From an international view of just health care, we need to go beyond the popular perspective of the contemporary Western egalitarian liberalism, becoming aware of the ever profound diversity and pluralism at the international level. A successful account of justice in health care will thus require more than what can be drawn from theories of justice.
Chapter Two

SUBSTANTIVE ACCOUNTS OF SOCIAL JUSTICE IN HEALTH CARE (A):

THE PRINCIPLES OF EQUALITY

This chapter addresses three contemporary moral accounts of health care allocation: Robert Veatch’s egalitarian account, Norman Daniel’s contractarian account, and Peter Singer’s utilitarian account. The moral core of each of these accounts is a particular principle of equality. Each of these accounts rests upon distinct fundamental premises and understandings regarding social justice. They all argue for more or less similar sorts of state-controlled health care allocation.

I. Equality of Objective Net Welfare: Veatch’s Egalitarian Account

1. The principle

Veatch holds an egalitarian moral theory. He argues that justice means equality (1981, p. 265; 1986, p. 5). A principle of social justice, for him, is tantamount to a principle of social equality.¹ The question left to explore is simply which principle of social equality

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¹ In talking about equality, it is always important to ask the question “equality with regard to what.” There can be equality with regard to income, wealth, opportunity, capability, achievement, liberty, right, etc. Simply claiming equality does not get us very far. As Amartya Sen observes, “every normative theory of social arrangement that has at all stood the test of time seems to demand equality of something - something that is regarded as particularly important in that theory” (1992, p. 12, emphasis original). Even Robert Nozick’s anti-egalitarian libertarianism is to require equality of libertarian rights.

Of course Sen’s observation is correct only to an extent. It does not fit to the relation between God and men in theological theories. The relation between God and men can be taken as absolutely unequal. See Engelhardt (1996, p. 96, note 84).
ought to be adopted, since forms of equality conflict. In other words, Veatch must decide which form of equality ought to be maintained equal in society to make sense of his egalitarian understanding of social justice. In fact, in the center of his account lies the principle of equal objective net welfare. To follow his interpretation of this principle, some crucial points are in order.

First, Veatch contends that this principle is only one of the prima facie deontological principles that similarly morally bind. Veatch identifies five of such principles. Besides the principle of justice, there are also the principles of autonomy, promise-keeping, truth-telling, and avoiding killing (1981; 1991, p. 96). Accordingly, within Veatch’s system, the principle of justice must be balanced with other principles in cases in which the other principles are also involved. For instance, suppose we have promised to offer health care to certain people who are actually not so medically poorly off as some others, the principle of justice would appear to require us to divert some care to the others in greater need, while the principle of promise-keeping would require opposing the shift (1991, pp. 96-97). Which principle will dominate in the final decision will depend upon how various prima facie principles are related to one another. For Veatch, there is no absolute order among these equally binding deontological principles

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2 Evidently, different forms of equality conflict with each other. For instance, if society wants to maintain equal opportunities for individuals, unequal outcomes will occur. On the other hand, if society wants to have equal outcomes, it has to maintain unequal opportunities. Moreover, if society wants to preserve equality of basic political and economic liberties, it cannot secure equality of opportunity or outcome.

3 According to Veatch’s understanding, these prima facie principles or duties are right-making characteristics of actions or practices. These are qualities of actions or practices that tend to make them morally right (1991, p. 84).
Second, objective net welfare is measured based upon the meeting of basic human needs, such as basics of food, clothing, shelter, medical care, and education. It should not be measured in terms of the satisfying of personal desires or preferences (1986, p. 136-137). From Veatch’s understanding, even if the conception of basic needs does not stand independently of value judgment, the value judgment that it involves is “so consistent and so predictable that we can treat it as fixed, as if it were an objective part of nature” (1986, p. 137). For Veatch, people require basic needs as particular resources to function themselves in such a way as to have an opportunity to be as well off as others. Thus, people’s value judgments may reach consensus on them. Moreover, Veatch asserts that equality of objective net welfare should be considered over a lifetime, not at a given moment only (1986, pp. 129-131).

Third, what the principle of equal objective net welfare really requires, Veatch emphasizes, is not equal outcome, but opportunities for equal outcome, i.e., opportunities for an equal level of well-being for all. It does not demand actual accomplishment of equality (1991, p. 91). Hence, Veatch contends that under his theory there should be no bar to rewarding real effort or merit. For him, the only problem in this regard is a technical one: to know how to separate real effort or merit from differences in ability. He believes that there is a rule of thumb which can offer help here: “it seems very unlikely that differences in outcome purely as a result of effort could result in much more than the range of one-half to double the average well-being” (1986, p. 133). Accordingly, the

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4 But Veatch argues for a joint priority of these deontological principles over the consequentialist principles - the principles of beneficence and non-maleficence (1981, pp. 293-305; 1991, p. 97).
range of one-half would give us the outer limits of the amount of variation in well-being that we can tolerate in the name of justice (1986, p. 134).

2. Health care

Veatch's general principle of social justice, namely the principle of equal objective net welfare, leads to a particular egalitarian principle of social justice for health care allocation: everyone ought to have an opportunity for a level of health equal as far as possible to the health of others (1981, p. 275). Accordingly, the state is under a moral duty to maintain this particular principle. Resources must be distributed and offered in such a way that all people will have an opportunity to be similarly healthy as far as possible. Moreover, Veatch specifies a series of concrete issues regarding the application of this principle.

First, should people be offered money that can be used to purchase health care or with in-kind health care services directly? Veatch claims that in-kind health care services are better than money provision. He holds this is so even in his alleged just world, where “objective net welfare, or generalized measures of the means to obtain welfare (such as money) are distributed fairly” (1981, p. 272). The reason is that, Veatch argues, unlike the needs for food, clothing, or shelter, people's health needs are distributed quite unevenly. Some are born healthy and strong, while others are severely ill and physically or mentally retarded. If the state through the means of money offers everyone an opportunity to be as healthy as others, it has to provide amounts of money to everyone based on his/her “unhealthiness index.” This will need “an enormously complex mechanism, such as a bureaucracy, with a point system for every naturally occurring
health risk factor, every adverse gene, or probability for exposure to infectious disease” (p. 272). Moreover, “it will quickly become extremely difficult to distinguish between the unhealthy persons who are justly unhealthy (because they have received a certificate for health care and traded it away) and others who are unhealthy and have not yet been compensated” (1991, p. 92). Hence, it is far simpler to distribute in-kind health care services equally in proportion to everyone’s health needs.

Second, should people be permitted to trade their health care for other goods? Veatch’s answer is no. In fact, it is in part from his consideration of avoiding such trades that he supports in-kind health care services rather than money offering for health care. He concedes that this is a very complex issue in our real world in which resources are not distributed justly (i.e., not distributed according to individuals’ basic needs). He sees that there are good reasons for allowing swaps between health care goods and other basic needs. First, many of the poor could stand to improve their overall welfare if they traded some of their relatively good health care coverage for some food or housing that they need desperately. Second, a principle of autonomy would surely support such a policy of permitting trades. Finally, the principle of social justice would seem to require such trades because it demands promoting the lot of the least well off and making them more equal to others in net welfare (1991, p. 94).

However, Veatch provides both pragmatic and theoretical considerations against such exchanges. From the pragmatic consideration, “the political reality may be such that a legislature will not substitute cash grants for health care” (1981, p. 273). Therefore, according to Veatch, people have to make a forced choice between in-kind health care services for everyone without allowing swaps and no welfare health care at
all. Theoretically, allowing such swaps would be tantamount to conceding defeat on the broader social problem of injustice in society. "It requires the creation of social institutions that acknowledge that injustice is part of the world in which we live" (1991, p. 95). Instead, for Veatch, the ideal position is this:

since the poor would be getting something approaching the share of health care they would get in a just world, we should not create an institutionalized practice of trades that would leave them with less health care. Rather, energies should be spent on getting more acceptable levels of support in the other spheres (p. 95).

Here there is also another position, the position of conscience, that Veatch believes is involved. According to Veatch, the holders of this position might say that even without the change they would desire [to make the world more equal in net welfare], their conscience would force them to favor the ethical behavior that would accord with the ideal, at least in the spheres over which they have control (pp. 95-96).

Third, how does the egalitarian view of social justice handle the problem of voluntary health-risk behaviors? People voluntarily smoke, omit exercise, drink vast quantities of alcohol, eat too much, expose to the sun excessively, use health-harming drugs, ski down dangerous mountains, drive recklessly, participate in automobile racing, play professional football - in short, engage in all manners of behaviors, knowing that they involve substantial risks to their health. For Veatch, since justice requires only an opportunity for net equality of health rather than actual equality, in cases where some choose not to take advantage of that opportunity, "they would not be justified in turning on the society and demanding additional resources in order to restore their health" (1981, p. 278). If
individuals are responsible to some degree for their health and their need for health resources, they should also be responsible for the cost involved (1980, p. 50).\(^5\) Hence Veatch argues that, for instance, "the marginal health care cost of a package of cigarettes can be calculated and added to the price of the cigarettes as a health fee" (1981, p. 279).

Finally, Veatch lays out a general health care system in accordance with his egalitarian understanding of social justice:

It might come in the form of an insurance policy with a specified range of coverage (say a $2000 per person per year package with prohibitions on or compensations for any special illness-based policy limits). Certain differences in coverage might even be tolerated... As long as everyone had benefits priced at $2000 and received coverage specified in the plan, somewhat different treatment plans would exist, but everyone would have an equal opportunity to be healthy (1991, p. 93).

The goal would be to arrange resources so that health care needs would, in general, be met about as well as other needs. "This means that a society would rather arbitrarily set some fixed amount of the total resources for health care" (1981, p. 275).\(^6\) The best way of funding such a national health insurance is out of general revenues based on a progressive income tax (1976, pp. 150-152).

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\(^5\) Veatch summarizes several models regarding whether taking health risks is voluntary: the voluntary model, the medical model, the psychological model, the social structural model, and a multi-causal model. He argues that only last model is the most reasonable one. This implies that, for him, at least to some degree individuals should be responsible for their health-risk behaviors (1980).

\(^6\) In his 1997, he proposes a fixed premium of $3500 per person per year for basic health care insurance.
3. Justification

From Veatch’s point of view, any account of social justice will depend upon a set of fundamental premises. Whatever manner one adopts to deploy one’s argument, one has to make a commitment to some key assumptions. Hence, in this regard, Veatch contends that the secular philosopher resembles the theologian: Both need to make “faith moves” (1986, p. 16). “While some people claim that they are offering argument for their fundamental premises, this will ultimately prove impossible” (1991, p. 84). For instance, we simply find that secular egalitarians asserting that justice is equality, “presuming it, acknowledging it, intuiting it, and finding it reasonable - everything but providing a decisive proof for it” (1986, p. 89). Hence, Veatch concludes that basic premises and commitments of secular philosophy are no more and no less than “disguised faith” (1986, p. 89).7 For Veatch, there will be no logically or empirically compelling reason why one set of “faith moves” ought to be made rather than another (1996, pp. 16-17). Hence, he argues, it is better for the defenders of any particular positions (especially egalitarian and anti-egalitarian positions) to state their premises clearly in the first place.

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7 Veatch uses Baruch Brody’s essay “Health Care for the Haves and Have Nots: Toward a Just Basis of Distribution” (1981) as an example to show how philosophers bootleg faith statements into their secular philosophical arguments. As Veatch sees it, Brody argues for taxing the better-off to provide health care for the indigent on the grounds that “justice demands this equalization of capacity to obtain basic needs” and the scheme is “to be viewed in the context of programs of redistribution aimed at promoting greater equality” (Brody, 1981, p. 151). Veatch contends that there is no place in Brody’s article where these basic presumptions in favor of egalitarian redistribution are defended. “They seem to be taken as the given starting point for the analysis suitable for justifying a particular taxation plan, but not themselves in need of justification” (Veatch, 1986, p. 90). Veatch suggests that Brody have obtained these beliefs from the Judeo-Christian tradition. “There is no evidence, but I am prepared to suggest that he is in fact bootlegging the presuppositions, the faith commitments, of that tradition. As an active practitioner standing within that tradition, where else could he get answers to these basic questions of ethics?” (1986, p. 91).
Veatch offers the following starting assumptions that lead to his egalitarian principle of social justice:

(1) Human beings are of equal moral worth in the sense that no human deserves a claim to more than or less than an equal share of available resources.

(2) The natural resources of the world should be seen as always having had moral strings attached to their use. They have never been ‘unowned’ and available for appropriation and use without conditions attached.

(3) Human beings have a prima facie responsibility as moral agents to use the resources of the world to move society toward a distribution of resources that is more equal (1991, p. 85).

Veatch concedes that there is no definite justification or logical priority in favor of any of these egalitarian assumptions. He contends that in the end people have to make a forced-choice or “faith move.” However, from his view, anti-egalitarians are in no better position than egalitarians. They must, Veatch argues, accept on faith at least one of the premises that are counter to those egalitarian assumptions cited above:

They must accept - on faith - that humans are not of equal moral worth in that at least some persons are entitled to more of the world’s resources than others, or they must accept - on faith - that there is no preexisting claims of the community on the natural resources of the world, or they must accept - on faith - that humans have no obligation to use the resources of the world to establish greater equality. Without at least one of these assumptions, the anti-egalitarian position collapses as surely as the egalitarian position does without its assumptions (1991, p. 86)
However, although Veatch argues that neither egalitarians nor anti-egalitarians are able to offer a knock-down argument for their fundamental assumptions, he provides a brace of reasons to show that reasonable people would accept his egalitarian assumptions and thereby in this sense his egalitarian principle of social justice is justifiable. For the sake of simplicity, I will distinguish and label the reasons that he offers throughout his writings as four arguments: The argument from tradition, the argument from convergence, assurance argument, and morality argument.

The argument from tradition invokes the claim that Veatch's egalitarian assumptions have prevailed in the Western Judeo-Christian tradition. Veatch affords a series of accounts of this claim. In the first place, all humans are of equal moral worth in several senses. In comparison to God, the omnipotent creator, the absolute, and the infinite center of value, all humans are equal in their finitude. From finite human views humans are surely unequal in many aspects, such as their usefulness, merit, or achievement. But in comparison to the infinite center of value, any differences among them count as nothing. Moreover, humans are all equal because they have all sinned and are under the same necessity of being saved by the free grace of God. Finally, all humans are of equal moral worth because they have common origin and the same fatherhood. As the children of God, differences among them are utterly trivial compared to their moral worth in the eyes of God (1986, pp. 66-70).

Second, according to Veatch's particular understanding of the view of the Judeo-Christian tradition, there was never a time in which there were unowned resources to be acquired on a first-come-first-served basis. All things belonged to God. Natural resources were a gift from God. Hence it is either that property should be held in
common, or that private property should be limited by the needs of others (1986, pp. 70-72).

Finally, there is the doctrine of stewardship. Humans are the stewards of everything God has conferred on them. A duty of stewardship is built on the model of brotherhood and common parentage, making the human community the protector of the welfare of those in need and using resources to maintain and restore equality (1986, pp. 72-75).

The argument from convergence shows that some secular philosophical assumptions converge with the explicitly egalitarian manifestations of the Judeo-Christian tradition, while there is no such consistency existing for anti-egalitarian side. A remarkable number of philosophers, Veatch observes, have arrived at doctrines or principles of justice that are strikingly similar to the egalitarian commitments of the Judeo-Christian tradition. The well-known examples are John Rawls, Ronald Dworkin, Thomas Nagel, Bernard Williams, and so on (1986, pp. 80-89).

Assurance argument is even more simple. When rational people seek to create a peaceable community, Veatch assumes, the only way for them to assure themselves of such a community is to accept a principle of equality of net welfare. "Otherwise those who are losers in the natural lottery may well band together against those who were the winners" (1991, p. 88).

Finally, Veatch provides a moral argument, which claims that the endorsement of the egalitarian assumptions of social justice is the natural response of those who adopt "the moral point of view." For Veatch, "even if it could be established that rational self-

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8 The motion of "the moral point of view" was originally laid out by Kurt Baier (1958). Since there are various justifications for rules of behavior, Baier argues that we need a
interested persons would impose only freedom as a side-constraint in order to create a peaceable community, this would not necessarily say anything about what is ethical” (1991, p. 88). Instead, persons ought to adopt “the moral point of view” (Baier, 1958). The moral point of view is a genuinely impartial position, from which the perspective of self-interest is abandoned and the welfare of each person is counted equally. No one is morally exempt, and no one is morally neglected. Under this point of view we are looking at the world from the perspective of anyone and for the good of everyone (1981, p. 119). Hence the principle of equal net welfare is “overwhelmingly attractive from the moral point of view” (1986, p. 110).

4. Critique

Veatch does not indicate clearly how his three fundamental assumptions logically lead to his egalitarian account of social justice. The core of his account, as we have demonstrated, is the principle of equal objective net welfare, which requires that everyone be offered with an opportunity of possessing such amount of resources that are sufficient to achieve a level of net welfare equal as far as possible to that of others. This conveys a quite particular and concrete sense of equality. But, the concept of “equal” or “an equal share of available resources” contained in his premises is too general and ambiguous. It might mean something like the requirement that his principle of equal net welfare carries. It might also mean something different, like equal division of resources, standpoint from which we can judge between good and bad reasons. Such a standpoint is “the moral point of view.” He lays down two conditions for “the moral point of view.” First, the moral point of view must, as Kant emphasizes, be one in which everyone is regarded as subject to the same rules; second, it must be one which is for the good of everyone alike (1958).
or equal income, and so on. It seems that Veatch does “boldly” state his fundamental assumptions (1991, p. 84), but he does not state them as clearly and accurately as he holds. In order to derive his particular egalitarian account of social justice from these assumptions, he must clarify the concept of equality included in his assumptions as being the conception of the opportunities of using resources for equal welfare. In this way his three fundamental assumptions should be further identified as follows:

(1) Human beings are of equal moral worth in the sense that no human deserves a claim to more than or less than a share of available resources for a level of welfare equal as far as possible to others.

(2) The natural resources of the world should be seen as always having had moral strings attached to their use. They have never been “unowned” and available for appropriation and use without conditions attached. The fundamental moral string attached is that their appropriation, ownership, and use should be conditioned by the requirement of equal welfare for all.

(3) Human beings have a prima facie responsibility as moral agents to use the resources of the world to move society toward a distribution of resources that is for a more equal level of welfare of all.9

With these identifications, Veatch’s assumptions come to match his egalitarian account of social justice. Only now are we able to examine his arguments for these assumptions in a clear way. Each of his arguments, as we shall illustrate in the following, suffers from a series of problems and difficulties.

First, Veatch fails to indicate persuasively that the Judeo-Christian tradition holds

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9 The emphases are added for the clarification.
any of his three fundamental assumptions. Regarding his first assumption, his argument
from tradition may have plausibly shown that all humans are of equal moral worth in the
Judeo-Christian tradition in the following senses: They are all finite in comparison with
God, the infinite center of value, they have all sinned and are under the same necessity of
being saved by the free grace of God, and they all have common origin and the same
fatherhood.\textsuperscript{10} It does not show, however, that in the Judeo-Christian tradition all humans
are of equal moral worth in the sense that each deserves a share of resources for a level of
welfare equal for all. Only this sense - each deserves a share of resources for a level of
welfare equal for all - is what Veatch needs for his argument. But he fails to offer any
evidence that this is care to the Judeo-Christian tradition. Indeed, even within the Judeo-
Christian tradition, the proposition that all humans are of equal moral worth can have
many different implications, as Veatch himself has illustrated. Consequently, his first
assumption carries a very particular sense on which his argument does not even touch.

A similar problem confronts his argument for the second and third assumptions.
It may well be true that, according to the Judeo-Christian understanding, the earth was
created by God and the resources therein can be used by humans only on certain attached
requirements. But the question here is which requirements are attached. What Veatch
needs for his account is a very special requirement, i.e., distribution of resources for equal
welfare. Is this the understanding of the Judeo-Christian tradition? Most probably no.

\textsuperscript{10} However, it is ambiguous and misleading to hold that “in comparison to an infinite, all
finite are equal” (1986, p. 66). It is true that in comparison with an infinite, all finite are
equal in one sense, i.e., in their finitude. It is not true that they are equal in all aspects,
such as intelligence, usefulness, merit, etc. This is to say, from the premise that all
humans are equal in their finitude cannot draw the conclusion that all humans are equal in
their moral worth. Moreover, it is bizarre to hold that “in comparison with the Absolute,
humans, in their finitude, are nothing, and any differences among us count as nothing”
(1986, p. 66). If this should be so, why bother caring about differences in welfare?
For instance, as John Locke sees it, since God has given the world to men in common for them to use for their advantage and convenience, everyone has a property right to what one has mixed his labor with, insofar as "there is enough, and as good, left in common for others" (Locke, 1980, #25-27, pp. 18-19). That is, unlike Veatch's, Lockean requirement is only that "enough and as good left in common for others." Moreover, it is far from clear why the doctrine of stewardship demands a move towards more equal welfare.

If the Judeo-Christian tradition does not contain the egalitarian sense of Veatch's account, then his argument from convergence loses its standing. Even if some secular philosophers share a position of the equality of net welfare, it has nothing to do with the Judeo-Christian tradition. They must offer an independent philosophical argument for their starting assumptions of the position.

Veatch's assurance argument states that the only way to assure a peaceable community is to accept a principle of equality of net welfare in case that "those who are losers in the natural lottery may well band together against those who were the winners" (1991, p. 88). This is not a moral argument. It is a psychological, sociological, or political theoretical judgment. However, what is morally important is not whether those who are losers in the natural lottery will band together against those who were the winners, but whether they have the moral authority to do so. In order to show this Veatch needs a different (moral) argument that he has never provided. On the other hand, it is unclear why, sociologically, a principle of equal net welfare can prevent the losers from banding together against the winners and thereby assure a peaceable community. For instance, if a loser happened to be a Marxist living in a capitalist society, why should he be satisfied with a new situation in which his opportunity for net welfare would be equal
to that of the previous capitalist? Why should he not rebel for a new socialist society in
which he would have even more opportunities than the capitalist? Evidently, one’s
motivation to act depends upon what theory of justice one holds to be true, which in turn
requires a philosophical argument for its legitimacy and authority.

The final argument, the argument from morality, might be the most powerful
argument that Veatch provides for his fundamental assumptions. The argument is based
on “the moral point of view,” which requires one to take an impartial position and count
everyone’s welfare equally. As long as one adopts this point of view, Veatch tells us, the
most natural response would be to endorse his egalitarian assumptions (1986, p. 110).
This, however, simply fulfills Veatch’s own moral intuitions. What “the moral point of
view” itself concretely requires is at best ambiguous. One can offer different candidates
for what is understood to be an impartial position or what amounts to counting
everyone’s welfare equally. Veatch’s egalitarianism is only one candidate. The other
well-known candidates are utilitarianism and libertarianism. For average utilitarians,
counting everyone’s welfare equally entails that we ought to take those acts (or follow
those rules) which will maximize average welfare. For classical (total) utilitarians,
counting everyone’s welfare equally implies that we ought to take those acts (or follow
those rules) which will maximize total welfare. On the other hand, for libertarians,
counting everyone’s welfare equally suggests that everyone has a right to forbearance
from unconsented-to interference with one’s private property or moral life (Buchanan,
1981). Veatch fails to show why the most natural response would be to endorse his
egalitarian assumptions rather than any of the others.

Since Veatch holds that both egalitarians and anti-egalitarians ground their
systems of thought in what amounts to "faith moves," he concludes that neither can employ the strategy of the burden of proof to defeat their counterpart (1986, p. 108). This could be true if there were only one type of anti-egalitarianism as Veatch noticed. What is parallel to Veatch's egalitarianism is the type of anti-egalitarianism that carries substantive moral assumptions. For instance, for both Plato and Aristotle, it was simply obvious that people were unequal in morally relevant ways and thus justice means to each according to his desert. However, Veatch fails to notice another type of anti-egalitarianism - the fall-back position of libertarianism. The libertarian agrees with Veatch that there are no clearly convincing arguments to establish a particular content-full account of justice, either egalitarian or non-egalitarian. Instead of building a particular position on the basis of some substantive assumptions as Veatch does, the libertarian turns to the procedural principle of mutual agreement as the source of joint authority for common action. This account is based on epistemological skepticism regarding the capacities of reason to establish a morally canonical pattern for the distribution of resources or the authority to impose such a pattern. Hence "the burden of proof must be Shouldered by the individuals or communities using coercive force on behalf of a particular view of justice or the good life" (Engelhardt, 1991, p. 105).

Veatch's argument for an egalitarian national health insurance suffers from a series of other difficulties. First, such a system cannot guarantee an equal opportunity for everyone to be healthy. The problem lies in the possible conflict between the principle of justice and the principle of autonomy in his deontological moral system. For Veatch, these principles are equally binding. The principle of justice requires that everyone enjoy the same health insurance policy, while the principle of autonomy permits persons to use
their own private resources as they see fit. True, Veatch believes that the function of the principle of autonomy has limitations. On his egalitarian view, there never have been any unowned resources out there to be possessed as a starting point of purely private property. The principle of autonomy might only “give persons the right to choose their own life styles, prolonging medical treatment - but it does not give people the right to dispose of as they see fit the resources for which they are society’s temporary custodians” (1991, p. 99). Nevertheless, Veatch has to face a significant challenge. Suppose a person developed a broadly useful computer program and obtains a patent and thus made a great deal of money. Veatch certainly would say that this invention was not made mainly by his effort, but was also generated by his abilities which he does not deserve. Based on his rule of thumb that we mentioned previously, he would argue that this person should not be allowed to make so much income as is “more than the range of one-half to double the average well-being” (1986, p. 133). Now Veatch would allow this person to have more money than the average level, as long as the amount he has does not double the average level. Suppose he uses all his extra money for additional healthcare services, in addition to what he already gets as all others. This indicates that he will have a better opportunity to be healthy than others.

Second, it is difficult for Veatch to avoid the infinite demand problem. His example regarding providing polio immunizations versus curing blindness is an easy one. He might be right in arguing that justice does not require us to divert polio immunizations away from the presently healthy in order to do research to “cure” blindness, because such diversion would cause the healthy to become medically worse off (1991, pp. 98-99). The serious problem of justice here for Veatch is not providing polio immunization versus
curing blindness. It is rather, for instance, consuming beer versus curing blindness, or even driving luxury car versus saving life. Since Veatch’s view of justice requires providing opportunities for equal welfare for everyone, how can it not require providing resources for those worst off human beings, like severely defected or retarded newborns, as long as more investment of resources can significantly improve their well-being (i.e., saving their life) at others’ comparatively much smaller cost (offering their resources)? Given that this is the matter of opportunities for some individuals’ life at stake, how can we stop offering resources if justice requires equal opportunities for well-being?

Third, it is puzzling that Veatch does not allow trade-offs between healthcare and other basic needs. Given that allowing trade-offs will promote the whole welfare of the traders, his position confuses the actual situation with the ideal situation, discounting its own ideal of making general welfare more equal. The position of conscience that he offers seems to be confused about what the ideal really is. The ideal is supposed to provide opportunities for equal net welfare, in which healthcare is only one aspect. The ideal is not to provide opportunities for only one particular welfare aspect, healthcare or any other. Hence, following his own argument, the right act is in any situation to achieve as many opportunities for equal net welfare as possible, rather than opportunities for a particular aspect of welfare. Within his own egalitarian logic, Veatch’s opposition to trade-offs is hard to comprehend.

II. Equality of Fair Opportunity: Daniels’ Contractarian Account

1. The principle
Daniels defends John Rawls' contractarian theory and holds the principle of equality of fair opportunity. He borrows this principle from Rawls' second principle of justice (1971). For both Rawls and Daniels, this principle is aimed to correct results from natural contingencies as well as social contingencies. However, according to Daniels' account, this principle does not require all opportunities to be equal for all persons. Instead, it requires only that opportunity "be equal for persons with similar skills and talents" (1988, p. 70). This qualification turns out to be important for his approach to the proper allocation of health services. The principle now requires only provision of medical care rather than other services for improving skills or talents.

2. Health care

Daniels argues for a universal national health care system. He sees such a system to be the requirement of the principle of fair equality of opportunity. From his view, any society wanting to maintain the principle of fair equality of opportunity as the requirement of social justice must provide universal health care coverage based on the needs of its citizens.

What is the scope of such adequate health care? For Daniels, a society may allow some kinds of luxury health care to be there for purchase. Nevertheless, he contends that "however the upper tiers of the health-care system are to be financed, there should be no obstacles - financial, racial, geographical, and so on - to access to the basic tier" (1985, pp. 79-80). According to his account, the basic tier "would include health-care services that meet health-care needs, or at least important health-care needs - as judged by their

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11 Rawls and Daniels use the phrases "the principle of equality of opportunity" and "the principle of fair equality of opportunity" exchangeably.
*impact on the normal opportunity range*” (p. 79, italics original). These services are “needed to maintain, restore, or compensate for the loss of normal specie-typical functioning” (p. 79).

A major difference between Daniels and Veatch regarding health care justice lies in Veatch’s principle of equal net welfare which must be balanced with other similarly binding moral principles (such as the principle of autonomy), whereas Daniels’ account of the principle of equality of fair opportunity leaves no room for compromising its requirement. For Daniels, a state must provide a national insurance to meet health care needs (or at least the important health care needs) - this is the requirement of social justice.

3. Justification

Daniels claims that his argument for a national health care “does not depend on the acceptance of any particular theory of justice, such as Rawls’ contractarian theory” (pp. 41-2). Rather, it is a “weaker, conditional claim” - just health care institutions require only that they are governed by a principle of fair equality of opportunity, provided two conditions obtain: “(1) an acceptable general theory of justice includes a principle which requires basic institutions to guarantee fair equality of opportunity, and (2) the fair equality of opportunity principle acts as a constraint on permissible economic inequalities” (p. 41). However, Daniels concedes that “the main theory which has incorporated a fair equality of opportunity principle is Rawls’ contractarian theory of justice as fairness” (p. 42). He also provides a particular way of extending Rawls’ theory to health care and thus offers a way of justifying his account of just health care in the
contractarian context (pp. 42-48). Hence I term his account a contractarian account.

Specifically, Daniels' account of social justice in health care system can be summarized in the following argument:

(A) Disease and disability are impairments of the normal biological functioning of a human individual;

(B) The normal biological functioning is necessary for a normal opportunity range available to a human individual;

(B) Therefore, disease and disability are impairments of the normal opportunity range otherwise available to a human individual; (A), (B)

(D) An individual's fair share of the normal opportunity range is the array of life plans he may reasonably choose, given his talents and skills (the normal opportunity range for a given society is the array of life plans reasonable persons in it are likely to construct for themselves);

(E) Disease and disability impair the normal opportunity range and thus restrict the array of life plans that an individual's talents and skills would have made available to him were he healthy; (C), (D)

(F) Therefore, disease and disability restrict an individual's fair share of the normal opportunity range; (D), (E)

(G) Social justice requires the society (or the state) to maintain fair share (or equality) of the normal opportunity range for its individuals;

(G) Therefore, a state ought to provide adequate health care to prevent and
treat disease and disability for its individuals.¹² (G), (F)

4. Critique

Daniels’ foregoing argument can be substantially challenged at each step. I will primarily focus on his three major premises, namely (A), (D), and (G).

Premise (A) sets down a notion of the normal biological functioning of a human individual, which is presupposed to be known independently of value judgments as well as a reference to particular environments. This notion is used by Daniels as an objective determination of disease or disability so that disease or disability can be regarded as a deviation from normal biological functioning. As he argues:

even if some conditions or behaviors historically have been *viewed* as diseases – for example, ‘dраТetomania’, the disease that made slaves run away, or masturbation - such views do not *make* them diseases. Whales were not fishes merely because people thought they were for centuries. Nor does the fact that many diseases are discovered and treated only when people complain about them make being an object of complaint a necessary feature of diseases (pp. 29-30, italics original).

Evidently, it cannot be true that human diseases are diseases only because humans

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¹² This argument has been outlined in his *Just Health Care*, Chs. 2, 3, and especially the following paragraph: “impairment of normal functioning through disease and disability restricts an individual’s opportunity relative to that portion of the normal range his skills and talents would have made available to him were he healthy. If an individual’s fair share of the normal range is the array of life plans he may reasonably choose, given his talents and skills, then disease and disability shrinks his share from what is fair” (pp. 33-34, italics original).
somehow view them as diseases. That would be an extreme position which cannot be
correct. However, can it be true that human diseases as diseases are completely
independent of any human views and complaints? This would constitute the opposite
extreme position in an account of diseases. Unfortunately, Daniels appears to hold the
latter extreme position. The problem is that neither of the two extreme positions is
defensible. As Kant persuasively argues, humans cannot know anything that is
uninterpreted or unconstructed through the concepts of the human mind. The
uninterpreted or unconstructed thing-in-itself can only be viewed by an all-knowing god,
but is totally beyond the scope of human knowledge. Insofar as human knowledge is
concerned, the object is always construed through human concepts. Accordingly, human
knowledge is always knowledge-of-phenomena, not knowledge-of-a-thing-in-itself. This
is to say, empirical knowledge inevitably includes certain explanations and evaluations as
its internal components, and the knowledge of disease and disability is no exception.

More importantly, the knowledge of disease and disability not only contains a
component of conceptual constitution and epistemic evaluation as does knowledge in
physics or chemistry, but also it contains a component of non-epistemic evaluation as the
knowledge of physics or chemistry does not. This is because, unlike judgments in
physics or chemistry, the judgment of a disease or disability lies in a general evaluation
that, all other things being equal, the disease or disability ought not to happen, and that if
it happens, it ought to be cured, treated, or at least alleviated. This sort of disvalue of any
disease or disability is an essential (and certainly necessary) feature of the language of
disease. A general complaint about a disease is that, ceteris paribus, it carries a disvalue.
Unless one would go so far as to believe that humans are able to hold a god-like objective
view on diseases and thus the human knowledge of diseases obtained from this view can be independent of particular human values and complaints, one could not reasonably deny human values and complaints to be a necessary feature of the language of disease. Analysis of the concept of disease discloses that there is no such a god-like view available for humans to find diseases objectively. Instead, at the core of human judgments of diseases always lies human value judgments which are in turn conditioned by natural, societal, and historical situations (see Engelhardt, 1996, Ch. 5).  

Sometimes it seems that Daniels is willing to accept certain normative feature of diseases. For example, he says that

it is enough for my purposes that the line between disease and the lack of disease is, for the general run of cases, *uncontroversial and ascertainable through publicly accepted models*, such as those of the biomedical sciences. It will not matter if what counts as a disease category is relative to some features of social

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13 The recent literature of the philosophy of medicine includes a great amount of debating essays between normativist and naturalist views of disease. Naturalists attempt to establish a notion of disease independent of individual expectations and social values. They want to discover objective diseases by appealing to species-typical functions. According to this view, “a disease is a type of internal state which is either an impairment of normal functional ability, i.e., a reduction of one or more functional abilities below typical efficiency, or a limitation on functional ability caused by environmental agents,” while “a normal function of a part or process within members of the reference class is a statistically typical contribution by it to their individual survival and reproduction” (Boorse, 1977, p. 562). Interestingly, even this naturalist view must begin with a normative assumption regarding a goal of bodily function: individual survival and reproduction. Without this value judgment, naturalists have no way to locate species-typical functions. However, why is individual survival, rather than species survival, the goal? And why is individual reproduction also the goal? The distinguished representative of naturalist view of disease is Christopher Boorse. See his 1976, 1977, and 1997. See also Daniels, 1985, esp. Chapter 2. Regarding normativist view of disease, see Engelhardt, 1976, 1996; Margolis, 1976; and Goosen, 1980.
roles in a given society, and thus to some normative judgments, provided the core of the notion of species-normal functioning is left intact (p. 30, italics original).

But if Daniels admits that a disease category is relative to some normative judgments, then his supposed "the core of the notion of species-normal functioning" would not be left intact, if by this "core" he means that disease (or species-normal functioning) can be determined uncontroversially and ascertainably through biomedical sciences alone. Like the concept of disease or disability, the notion of species-normal functioning cannot be determined independent of value judgments. The debates around homosexuality, sickle cell disease, and color-blindness are well-known examples in this regard. In order to make canonical disease (or species-normal functioning) judgments, one needs a canonical vision of normal goals and normal environments. Modern societies have witnessed a diversity of competing visions and cannot know which vision is objectively canonical by sound rational argument. Certain disease judgments are extremely controversial and unascertainable, because people's values are in substantial conflict. Hence, the "core" that Daniels hopes to retain cannot be retained.

If these considerations stand, then Daniels' premise (A) has to be revised as

(A)' Disease and disability are impairments of the normal biological functioning of a human individual in accordance with a particular vision of normal biological functioning;

It is only through a particular vision that we can find whether, for instance, homosexuality is normal biological functioning or impairment of normal biological functioning.

Let's now turn to premise (D). (D) says "An individual's fair share of the normal
opportunity range is the array of life plans he may reasonably choose, given his talents and skills (the normal opportunity range for a given society is the array of life plans reasonable persons in it are likely to construct for themselves). Obviously, this is equivalent to the two following statements:

(a) One’s share of the normal opportunity range is the array of life plans one may reasonably choose, given one’s talents and skills.

(b) One’s *fair* share of the normal opportunity range is the array of life plans one may reasonably choose, given one’s talents and skills.

Even if we put aside our challenge to the notion of the normal opportunity range as suggested in our previous discussion of (a), (b) is far from uncontroversial. Daniels fails to distinguish fair and fortunate, or unfair and unfortunate. He appears to hold an idea of natural justice - it is fair for one to be able to reach the array of life plans that one may reasonably choose, given one’s talents and skills. But others can strongly contend that with regard to many situations in which one is not able to reach the array of life plans that one may reasonably choose, as in those caused by natural diseases without anybody’s fault, it is merely unfortunate, not unfair. Therefore, (D) should be revised as

(D)' An individual’s fair share of the normal opportunity range, *in accordance with a particular vision of fairness*, is the array of life plans he may reasonably choose, given his talents and skills.

Finally, premise (G) relates Daniels’ theory to accounts of social justice. (G) says that “social justice requires societies (or the state) to maintain fair share (or equality) of the normal opportunity range for its individuals.” This premise is directly introduced from Rawls’s principles of justice. Although Daniels claims that the principle of fair equality
of opportunity does not necessarily depend upon Rawls' theory, the most famous and influential theory of social justice that includes such a principle remains the Rawlsian theory.

Daniels expects that (G) might be implied by utilitarianism, too. Although he admits that he has never seen a persuasive utilitarian argument of this sort, he does not rule out the possibility that "a principle of fair equality of opportunity might be part of a system of principles, an ideal moral code, general compliance with which produced at least as much utility as any alternative code" (p. 42). Whether this can be the case or not, one thing is clear. The fundamental moral principle of classical utilitarianism, as Sidgwick formulates it, is the principle of general happiness (or maximum utility). Even if a principle of fair equality of opportunity can be derived from this fundamental principle, it can only be a secondary one. Only when establishing it contributes to general happiness can it become part of the utilitarian requirements. Whenever it does not, it will be overridden. Indeed, in the context of the classical utilitarianism, it does not matter whether everyone is guaranteed a fair equality of opportunity, as long as general social utility is maximized. In other words, a utilitarian does not take seriously the distinction between persons with regard to the distribution of utility or happiness. Evidently, it is difficult for Daniels to establish the principle of fair equality of opportunity in a utilitarian context, as long as he holds that fair opportunity cannot be subordinated to the principle of general happiness. Moreover, given that one intention of Rawls' theoretical construction is to defeat the utilitarian theory because the latter does not take the distinction between persons seriously, it is weird that Daniels thinks his Rawlsian principle of fair equality of opportunity could be part of the utilitarian system.
Daniels concedes that it is "far less likely that a libertarian theory would be compatible with any such fair equality of opportunity principle" (p. 42). Still, he thinks that libertarians could support this principle and its implications. However, Daniels overlooks a crucial feature in libertarianism: a distinction between a large-scale state and particular communities. For instance, under Engelhardt's interpretation, the outcome of the Hegelian account of social justice is libertarian. It does not support any redistributive action imposed by the state according to one particular understanding of justice or fairness. Indeed, libertarians insist on such non-imposition not because they give individual liberty high value, but because they see the inability of reason to discover a universal and content-full principle of fairness or justice that can be used by the society to impose a redistributive pattern on all particular communities. Given that the state includes a variety of particular communities following different and often conflicting principles of justice, Daniels' principle of fair equality of opportunity can be the principle practiced by some community that endorses it. However, at the level of general society (i.e., among different particular communities), libertarians would stress that only a procedural principle (e.g., Engelhardt's principle of permission or Nozick's understanding of rights as side constraints) should regulate. A principle of fair equality of opportunity can be employed among different communities only under the qualification of such a procedural principle. For instance, "fair equality" can mean the equality of mutual respect, not using any person without that person's permission. In this way it has been transformed to a content-less principle. It will be in essence equivalent to "a formal equality of opportunity" that Rawls discusses and abandons in his process of constructing his principles of justice (Rawls, 1971, p. 72). For libertarians, different
content-full principles can be accepted in different communities, in which people pursue their particular goals and values as they see appropriate. Again, among those goals and values, there may be the principle of fair equality of opportunity as Rawls or Daniels interprets, but it should not be imposed by state force upon other communities or persons that do not so believe, because libertarians insists that that kind of force cannot be morally justified.

In short, the classical utilitarian would not take the principle of fair equality of opportunity seriously when it does not contribute to maximizing general social utility. The libertarian does not accept that this principle ought to be maintained at the level of the state because it cannot be universally justified by sound rational argument.

However, even for those who may accept a principle of fair equality of opportunity at the state level, they may not accept Daniels' particular interpretation of it. Daniels roughly inherits Rawls' attack on pre-institutional desert: Nobody deserves the advantages that his character or natural abilities make possible, because nobody deserves his own character or abilities. Though Daniels asserts that "nothing in my approach is incompatible with encouraging people to adopt healthy life styles" and that "I do not believe that my account forces us to ignore the source of health-care risks in assigning such [financial] burdens [of health care]", yet he underscores that

it is not obvious we must take the source [of disease] into account. In any case, at this point little more can be said because much depends on very specific details of social history. In the United States, government subsidies of tobacco industry, the legality of cigarette advertising, and special subculture pressures on key groups - for example, teenagers - all undermine the view that we have clear-cut
cases of informed, individual decision-making for which individuals must be held fully accountable (p. 56).

Even if this particular consideration of individuals' non-responsibility for their health status is accepted, Daniels' interpretation of fair equality of opportunity can still be charged, like Rawls', with mistakenly abandoning the consideration of desert. As George Sher argues:

Just as persons are more than utilitarian centers of preference-satisfaction or frustration, and more also than featureless Rawlsian centers of volition, so too are they more than the bargain-strikers and improvers of resources who dominate Nozick's political philosophy. Because each of these theories focuses too exclusively on one aspect of persons, each abstracts from their full particularity, and so ignores many morally significant differences between individuals. ...how better to capture the moral importance of the differences between persons than to say that each person uniquely deserves things for precisely what he does, and for precisely what he is? (1987, p. 211)\(^ {15} \)

\(^ {14} \) I think this consideration is doubtful in many respects. For instance, if one is found a lung disease and is told by the physician to stop smoking in case the disease would become more severe or be re-contracted after treatment, then one continues to smoke and makes the problem more severe. Is he not significantly responsible for the problem? However, I will not address such issues in this essay.

\(^ {15} \) It is interesting to note the differences in understanding the distinction between persons among some leading American philosophers: for Rawls, utilitarianism does not take the distinction seriously because it extends "to society the principle of choice for one person" (1971, p. 27); for Nozick, Rawls's theory does not take the distinction seriously because it treats natural talents as a common asset (1974, p. 228); for Sher, Nozick's theory does not take the distinction seriously because it places an exclusive emphasis on rights-generating activities without considering the issue of desert (1987, pp. 210-211); for Engelhardt, Sher's theory of desert does not take the distinction seriously, because it overlooks the fact that people hold different views on desert.
Accordingly, if Sher were to agree that social justice requires a principle of fair equality of opportunity, he would give the principle an interpretation differing from Daniels'. Specifically, he would not agree on any absolute "social obligations" to offer a person a basic tier of health care which, according to Daniels, "would include health care services that meet health care needs, or at least important health care needs - as judged by their impact on the normal opportunity range" (1986, p. 79, italics original), no matter what that person does or is. For Sher, among the poor who are unable to buy health care insurance for themselves, distinguishing the "deserving poor" and the "undeserving poor" is very important. Society has an obligation to meet health needs (and other needs) only of the "undeserving poor", not of the "deserving poor", because, according to Sher, desert consideration should be an internal part of the requirement of a principle of fair equality of opportunity. Sher would not think it unfair not to provide health insurance through public resources for a poor person "who is now unwilling to work" for none of good reasons. Rather, Sher believes that not to provide free healthcare to such a person may precisely be the requirement of fairness because the person is a deserving poor (1983, pp. 9-12).

Consequently, even if we put aside the critiques from the utilitarian and libertarian, Daniels's premise (G) should be revised as

(G)' One kind of social justice requires societies (or the state) to maintain fair share (or equality) of the normal opportunity range for its individuals without the need of considering their desert.

Now, as we have seen, all three crucial premises that Daniels employs are derived from certain particular points of view. These points of views do not hold from other
perspectives. Accordingly, his conclusion (H) is secured only in the context set by these particular premises. However, given that Daniels fails to offer convincing arguments for these particular premises, his theory of healthcare justice does not carry the moral strength that he expects.

III. Equal Consideration of Interests: Singer’s Utilitarian Account

1. The principle

Singer holds a utilitarian theory. Its basic principle is equal consideration of interests (1993, p. 21). It requires one to take into account the interests of all those affected by one’s decision, no matter whose interests they are. According to Singer, this consideration naturally leads to the utilitarian conclusion that one ought to adopt the course of action that most likely maximizes the interests of all those affected.

As a utilitarian, Singer judges moral rightness according to consequences, and measures consequences in terms of the degree of interest-satisfaction. Accordingly, an action (policy, or system) is morally right if and only if it maximizes the interests of all affected by the action (policy, or system). By “interests” he generally means desire-satisfaction (1993, pp. 13-14). As he sees it, the difference between classical utilitarianism based on pleasure and pain on the one hand and his utilitarianism based on interests (desire-satisfaction) on the other may disappear, because it may be correct to suggest that “classical utilitarians like Bentham and John Stuart Mill used ‘pleasure’ and ‘pain’ in a broad sense that allowed them to include achieving what one desired as a ‘pleasure’ and the reverse as a ‘pain’” (p. 14).
2. Health care

Singer's theory of health care justice can roughly be summarized in the following argument:

(a) A national health service produces the better consequences than any other alternatives;

(b) Social justice (or ethics) requires a human action (decision, or system) to be performed (made, or established) in such a way that produces at least as good consequences, on balance, for all affected as any other alternative;

(c) Therefore, social justice requires a national health service.

By a national health service, Singer means a state-run, single-tier, and all-encompassing health care system. First, it "must be financed by taxation" (1976, p. 188), and "it may be paid for by a progressively graduated income tax, and distributed to all irrespective of income" (p. 190). Second, doctors are paid "on some basis other than the cost of the treatment" they prescribe so that unnecessary treatment may be avoided (p. 189). Finally, it differs from a system of universal insurance (such as that which Daniels supports) in that the latter provides only "a basic level of care for everyone", allowing the rich to buy better treatment for themselves, while a national health service provides "an integrated health service that is used by people of all classes and races", that is, it is an equal treatment for all in need (p. 191).

3. Justification

Singer recognizes that a national health service does "limit the freedom of the taxpayer to
decide for himself how much he shall spend on health, and how much on other items” (p. 188). However, he insists upon his premise (a), a national health service produces the better consequences than any other alternative. Supporting this view, he lays out the following three reasons.

First, “it may be that the community, acting together, can achieve goods that the individual could not achieve, no matter how much he decided to spend on health care” (p. 188). According to Singer, individuals are not able to achieve certain “goods” in health care through the market mechanism because “the special nature of medical care may make it unsuited to market control”. The market answer to the uncertainty of an individual’s need for extensive medical care is private insurance. Private insurance, however, “tends to be extremely expensive for ordinary visits to a doctor, because a doctor, in the privacy of his office, is not subject to supervision from his peers or anyone else, and so might prescribe unnecessary treatment in order to increase his remuneration from the insurance company” (pp. 188-9). Therefore, according to Singer, it is better to have a national service that pays “the doctor on some basis other than the cost of the treatment he prescribes” (p. 199).

Second, national health service “is an effective means of redistributing income, since it may be paid for by a progressively graduated income tax, and distributed to all irrespective of income”. This will especially assist the poorest, “since they will pay little or no tax, and receive essential services that they could not otherwise afford” (p. 190). Singer admits that this way of assisting the poor contains an element of paternalism, because they are assisted with services rather than with cash, so that their freedom to make choice as they like is limited. However, on Singer’s view, the poor are better off
with the kind-services rather than with cash-provision: "even if they were able to buy adequate medical services with the money we gave them, some at least would spend it less prudently, so as to gain short-term satisfactions at a cost of greater distress and suffering in the long run" (pp. 190-191).

Third, "the nature of the community that we live in" makes it "desirable" that the community "be integrated in certain fundamental areas of life, rather than being divided along lines of class or race" (p. 190). Presumably, by "community" in his essay, Singer means "the state," because he addresses national health service. Unfortunately, though he mentions "the nature" of the community (or the state), he never clarifies what that nature is. Presumably, being a utilitarian, he understands a state to be a community which ought to pursue the best interests of all individuals living in it. Indeed, it turns out that by "integration" he means "equality". As he says, "the knowledge that when it comes to vital things like medical care we are all in it together, and your money cannot buy anything that I am not equally entitled to, may do a good deal to mitigate the effects of inequality in other less vital areas, and create the atmosphere of community concern for all" (pp. 190-191, italics added). Hence, for Singer, the nature of the state is in harmony with a national health system which provides equal services to everyone, irrespective not only of one's race or class, but also of whether one is able to pay for them or not.

4. Critique

All these reasons that Singer has afforded are substantially defective. They are problematic even when we concede his fundamental utilitarian principle, i.e., one ought
to adopt the course of action that most likely maximizes the interests of all those affected. Accordingly, in the following I will discuss their problems only within the context of utilitarianism. We will first find out whether these reasons can support a national health service as Singer argues, even if we accept Singer’s basic utilitarian principle.

Concerning his first argument about the problems of private insurance system, the relevant facts and possibilities are at best unclear. For one thing, though the major worry that Singer has regarding private health insurance is the possibility of “extremely expensive” cost incurred by “unnecessary treatment” in ordinary visits to a doctor because “a doctor, in the privacy of his office, is not subject to supervision from his peers or anyone else”, yet ordinary visits do not account for a significant part of the immense health expenditure in many developed countries like the United States. Instead, much more is spent in hospital care (especially in ICUs), in using high-tech medicine, where a doctor is usually subject to “supervision from his peers” or someone else. For instance, in 1996, 35 percent of the US national health expenditures was spent on hospital care, while 19 percent was spent on physician services (which must include services by both private and hospital physicians) (The Nation’s Health Dollar: Calendar Year 1996).\footnote{The other spending is: 8 percent for nursing home care, 12 percent for other spending, and 26 percent for other personal health care. Other personal health care includes dental, other professional services, home health care, drugs and other non-durable medical products, vision products and other durable medical products, and other miscellaneous health care services. Other spending covers program administration and the net cost of private health insurance, government public health, and research and construction (The National Health Dollars: Calendar Year 1996).}

Indeed, it is high-tech medical diagnosis and treatment in hospitals, rather than ordinary visits to a doctor in his private office, that are significantly responsible for difficulties in combating medical expenses. Obviously, this fact would pose more serious
challenge to a national health system like the one that Singer advocates than to a private insurance system, because it is in the former system, not in the latter, that a policy of rationing medical care has to be made by public policy makers rather than would-be patients themselves. The recent growth of managed care organizations in the United States reflects the facts that (1) more and more individuals recognize that rationing in medical care is unavoidable, and (2) individuals want to accept and choose among different rationing approaches offered by managed care organizations. Indeed, without a rationing policy that constrains certain expensive medical services, a society with a national health service like Singer’s will have no resources left for its citizens to enjoy life. This consequence cannot be desirable for utilitarians. However, if a society does adopt such a rationing policy, then it has to confront the situation in which some individuals will use their own money to purchase the medical services that are not offered through public fund or engage in health advantaging strategies unavailable to the poor (i.e., health fitness programs). These may lead to inequalities in life expectancy and health. If Singer’s account tolerates this situation, then his dream of the equal health care for all is broken. If it absolutely prohibits any private investment in healthcare, a thorny burden is on Singer to tell us why. Even if Singer wants to have an absolute equal income for everyone (it turns out that he does not so want), he should still allow individuals to spend their income at least in somewhat different ways.

On the other hand, however, insofar as individuals control their own money, they can cooperate to form insurance in ways that encourage and manipulate doctors to provide more information about their medical charges. This will make doctors enter a more competitive market for patients, and the amount of their charges will be one factor
among others (like quality of their treatment) that significantly influences their careers. Besides, as a careful study has shown, some of the usual comparative observations, particularly those unfavorable to a private health insurance system like the one existing in the United States, are misleading because they are based upon misleading methodologies (Brody and Lie, 1993). In short, it may not be the case that the problem of overcharging caused by unnecessary treatment cannot be effectively dealt with by a private health insurance system.

Finally, even if we concede the problems and imperfections that a private insurance system would have, a national health service would lose its promise for other reasons. Even if health care is much cheaper under a national health service than under a private insurance system, it is very difficult to avoid problems such as low quality of care, inefficiency of services, a long waiting line, a black market, and even universal bribery.¹⁷ Indeed, experiences tell us that a national health service must encounter the following problems: 1. money drain - some people go abroad to get treatments that are not provided or poorly provided by a national health service; 2. brain drain - good physicians go abroad to make better careers or obtain higher salaries; 3. corruption - people bribe physicians or health administrators to get better treatment or avoid waiting in a long line; and 4. frustration - people’s freedom to spend their own money in their preferred way is limited. With these problems, the merit of a national health system dims.

¹⁷ The quasi-national health service in China provides a useful case in this regard. I say “quasi-national” because it does not cover all Chinese. Instead, it covers only about 15 percent of the population under the state medicine. It has suffered all kinds of social and ethical problems and calls for significant reform in the present. For information about Chinese health care system, see Du, 1999; Wang, 1999; Luo, 1999.
With regard to Singer’s second reason (a national health service offers “an effective means of redistributing income” through “a progressively graduated income tax”), by supporting a progressively graduated income tax Singer has himself deviated from the utilitarian track set by the classical utilitarians like J. S. Mill and H. Sidgwick without providing a necessary justification. As Mill sees it, “to tax the larger incomes at a higher percentage than the smaller, is to lay a tax on industry and economy; to impose a penalty on people for having worked harder and saved more than their neighbors” (1970, Bk. V, II, 3). Accordingly, Mill does not support a progressive income taxation, except for legacy and inheritance. Similarly, for Sidgwick, “if we protect the health of a starving person by giving him necessaries at the expense of the community, our action inevitably involves to some extent the evils of communism whatever its intention may have been: that is, it tends to decrease the inducements to labour, forethought, and thrift in two ways, (1) by distributing to paupers a certain quantum of unearned commodities, and (2) by taking from non-paupers a corresponding portion of what they have earned or saved” (1901, pp. 533-4). Accordingly, Sidgwick is very dubious about ensuring a legal right to relief from distress. Instead, he appears to support voluntary almsgiving with the assistance of government’s organization. Clearly, for both Mill and Sidgwick, enforcing a progressive income tax is against the maximization of general interests.

Singer claims that “it is hardly necessary to describe the distress that a person may feel if he requires medical care but is unable to afford it”. He also believes that “the security and peace of mind that arises from knowing that one will never be in this situation is one of the greatest benefits that a society can bestow on its poorest citizens” (p. 190). I assume that no one would deny that there was some truth in these assertions.
However, within the utilitarian context set by Singer, I do not know what outcome we will get by balancing the amount of utility-gaining from “the security and peace of mind” and the amount of utility-losing from levying a progressive income tax under Singer’s favorable national health service. Given that such a system to “lay a tax on industry and economy; to impose a penalty on people for having worked harder and saved more than their neighbours”, and “to decrease the inducements to labour, forethought, and thrift”, I suspect that the outcome may not be a plus. In any case, given the reasonable considerations of Mill and Sidgwick, it is far from clear whether, from a utilitarian perspective, a national health service financially supported by a progressive income taxation would produce the best consequences, though Singer claims that it would.

As to his third reason (the nature of the community), it seems that Singer heavily relies on his notion of “vital things”. If my understanding is correct, then Singer’s argument in this respect can be summarized in the following steps:

(a)' The nature of the state is such that it ought to pursue the maximum interests of all its individuals;

(b)' Certain vital things influence the interests of individuals fundamentally;

(c)' Therefore, the nature of the state requires that it guarantee these vital things equally to every individual irrespective of one’s ability to pay for them;

(d)' Health care is one of such vital things;

(e)' Therefore, the nature of the state requires that it guarantee health care equally to every individual irrespective of one’s ability to pay for it.

Given the utilitarian context, one could accept (a)'. Regarding (b)’, it is not quite clear that what Singer refers to by “vital things”, in addition to health care that he mentions.
Presumably, he has in mind such things as food, shelter, security, education, etc. Thus let us grant (b)', too. However, (c)' cannot be derived from (a)' and (b)'. In order to get (c)', one needs one more important premise: by guaranteeing the vital things equally to every individual (irrespective of one's ability to pay for them), the state maximizes the interests of all individuals. Can this premise stand firm?

As we mentioned previously, classical utilitarians were worried about the undesirable results of equal distribution of wealth, though they believed that a more equal distribution tends prima facie to increase social utility. For Sidgwick, in taking any government's interference to obtain more equal distribution, utilitarians must take into account "loss through increased idleness, decreased saving, lessened efficiency of capital, pressure of population, checked growth of culture" (1901, pp. 517-24). Given these undesirable consequences, Sidgwick did not even endorse an imposition of a legal right to relief from distress upon societies, let alone guaranteeing vital things equally distributed to everyone.

However, Singer does not consider these problems. He simply wants a more equal system. It seems to me that the history of the socialist countries in this century has vividly witnessed the strength and correctness of the classical utilitarian considerations made by Sidgwick and Mill in contrast with the egalitarian dream by Singer. As a matter of fact, the more equal distribution of vital things in socialist countries produced far less total interests for their individuals than the less equal distributive system employed in the capitalist states. With regard to health care in particular, it is roughly the same story. This constitutes a very bad news for Singer's argument. Indeed, in order consistently to justify an equal system for distributing vital goods, Singer needs to be a pure egalitarian.
But he is an egalitarian utilitarian. An equal distribution is justifiable for an egalitarian utilitarian only when it tends to maximize the interests of all people. When it does not, a coherent utilitarian must drop it. Accordingly, the argument implied in Singer’s third reason is hard to sustain.

In short, if these considerations are correct, then Singer’s first major premise for a national health service (“a national health service produces the better consequences than any other alternatives”) is brought into question. It fails even on utilitarian grounds.

Now we turn to Singer’s second premise for a national health service:

(b) Social justice (or ethics) requires a human action (decision, or system) to be performed (made, or established) in such a way that produces at least as good consequences, on balance, for all affected as any other alternatives.

Obviously, this is the fundamental moral principle of utilitarianism expressed in the field of social justice. One thing that may be worth discussing is that Singer thinks that we very swiftly arrive at an initially utilitarian position once we apply the universal aspect of ethics to simple, pre-ethical decision making. This, I believe, places the onus of proof on those who seek to go beyond utilitarianism. The utilitarian position is a minimal one, a first base that we reach by universalizing self-interested decision making. We cannot, if we think ethically, refuse to take this step. (1993, p. 14)

Does this add more weight to the epistemic status of utilitarianism? I doubt it. The universal aspect of ethics is similar to “the ethical point of view” that we discussed regarding Veatch’s egalitarianism. It is also similar to Kant’s concept of universalizability. It formally requires that similar situations be treated similarly. How
can this render the utilitarian position an immediate conclusion? It is true that universalizability does not allow one to hold a pure egoist position ("everyone should maximize my interests"), insofar as one admits oneself being among others with similar interests. But universalizability is in perfect harmony with a universal egoist position ("everyone should maximize one's own interests"). Compared to the utilitarian position ("everyone should maximize the interests of all"), the universal egoist position is similarly suggested by the requirement of universalizability. Even other ethical positions, such as the individual right theory ("every individual has certain rights that should not be violated"), are equally close to the concept of universalizability. Singer fails to show us why the utilitarian position is the first base that we must reach as long as we want to universalize self-interested decision making.

Presumably, Singer's premise (b) holds only in the utilitarian context. It is to beg the question to say that it should be accepted equally by non-utilitarians. However, since Singer's premise (a) fails even from the utilitarian points of view, his conclusion (c) ("social justice requires national health service") cannot be secured.

IV. A Critical Summary

Veatch, Daniels, and Singer each invoke a principle of equality to account for social justice in health care. But they advocate different equalities. In their own terms, Veatch's principle is the principle of equal objective net welfare. Daniels' principle is the principle of fair equality of opportunity. And Singer's principle is the principle of equal consideration of interests. Although each is a principle of equality, they address
different aspects that, according to them, society ought to make equal for every individual.

In their concrete requirements, these principles also have different implications. Veatch’s principle of equal objective net welfare does not demand equal outcome of net welfare, but equal opportunities for equal outcome of net welfare. Veatch allows giving credit for real effort or merit. He is ready to tolerate inequalities in net welfare generated by differences in real effort as long as such inequalities do not double the level of average well-being. In short, his principle demands that individuals with the same amount of effort obtain equal level of well-being. On the other hand, Daniels’ principle of fair equality of opportunity demands equal opportunities for persons with similar talents and skills. It does not require all opportunities to be equal for all persons irrespective of talents and skills. However, because he pays special attention to the responsibility of society for individuals’ behaviors, he does not even allow inequalities in distribution due to different individual effort. Finally, Singer’s principle of equal consideration of interests demands that society maximize the interests of all affected by public policies. This leads, according to him, a strict egalitarian distribution of wealth in society, without the need of considering talents, skills, or efforts on the part of individuals.

Regarding the measurement of equality, both Veatch and Daniels employ a concept of basic human needs. According to them, such basics as food, clothing, shelter, medical care, and education are basic human needs. Moreover, following Rawls in principle, Daniels argues that medical care, like education, affects individuals’ opportunities specifically. Hence medical care should be dealt with particularly under his principle of fair equality of opportunity, without being left to the arrangement of money
as other basic needs are. For Singer, although he states that equal interests are measured by desire-satisfaction, he appears to believe that the desires of individuals are and should be quite similar, especially for those desires for vital things like medical care. When such desires are different, Singer stands ready to argue against any desire that differs from his (e.g., he supports the kind-service rather than cash-provision health care to the poor, even when the poor prefer the other way around).

Regarding health care, Veatch, Daniels, and Singer all support that the state offers equal in-kind health care services rather than to provide money for individuals to purchase health care by themselves. For Veatch, the in-kind services are preferred because of a practical difficulty. Given that his principle requires that the state offer health care in a way that everyone has an opportunity for a level of health equal as far as possible to the health of others, if the state offers healthcare through cash payments, it has to provide amounts of money to everyone based on his/her "unhealthiness index." It will be practically impossible to obtain such an "unhealthiness index." Therefore, the in-kind services should be the option. However, Singer chose the in-kind services because of his paternalistic considerations. He is afraid that, if money is offered to everyone for healthcare, some would spend it less prudently at the cost of their long-term interests. Finally, it is presumable that Daniels supports the in-kind healthcare services for reasons similar to Singer's. Individuals may not spend money in maintaining or restoring their normal biological functioning, leaving the state having failed to ensure fair equality of opportunity.

As to the issue whether luxury healthcare is allowed for purchase by individuals through their own resources, Singer clearly answers no. He wants a state-run, single-tier,
and all-encompassing healthcare system. However, Daniels allows such an upper tier of healthcare after a basic tier of healthcare is guaranteed for everyone. Moreover, it is presumable that Veatch would also allow such luxury healthcare, given that his principle of justice is only one of a set of equally binding deontological principles. Other principles, such as the principle of autonomy, would lead to the existence of luxury healthcare, because individuals tend to spend their money differently in accordance with their distinct preferences, desires, and expectations.

Veatch, Daniels, and Singer all fail to offer persuasive argument for their respective principles of equality. Indeed, each simply assumed his own principle as the founding point of departure for social justice, ignoring other similarly plausible principles. What is worse, even if we grant their particular perspective concerning social justice, they still fail to offer a consistent account of the health care justice that they each respectively advocate. In the case of Singer, granted his utilitarian understanding of social justice, his countenance of a national health service cannot be convincingly defended, because a national health service does not necessarily promote utilitarian values as efficiently as other types of health care deliverance. In the case of Veatch, an internal contradiction is involved in the equal healthcare system that he advocates. Because the principle of autonomy is similarly binding as the principle of justice (i.e., his principle of equality) in his system, the predictable conflict between these two principles undermines the necessity of his conclusions. With regard to Daniels, granted his principle of fair equality of opportunity, he still needs the assumptions of very particular senses of normal biological functioning and of fairness, ignoring the other senses of these terms that are at least equally forceful. Intellectually, such strong assumptions have put
the national health care delivery that he supports in a very weak position. Others who do not accept such assumptions have good reason to ask why they should accept Daniels' account of national health care delivery.
Chapter Three

SUBSTANTIVE ACCOUNTS OF SOCIAL JUSTICE IN HEALTH CARE (B): THE DOCTRINES OF RIGHTS

This chapter examines three more substantive accounts of social justice regarding health care allocation: David Friedman's economic account, Charles Fried's deontological account, and Tom Beauchamp and James Childress' mid-level-principle account. I take the moral core of each of these theories to be a particular doctrine of rights. They each base on their respective doctrine of rights to argue for a particular pattern of health care allocation.

Unlike Veatch, Daniels, and Singer who address the issue of justice in health care allocation in terms of equality among individuals, Friedman, Fried, and Beauchamp and Childress explore the issue according to considerations of individual rights. The former group of theorists begins their exploration with the question of which form of equality should be maintained for individuals in society, while the latter group focuses on the issue of what rights individuals ought to have. Just as principles of equality give the former group useful tools to bring together their considerations, doctrines of rights offer the latter group with general frameworks to integrate different ingredients into systematic accounts. However, crucially, no matter whether one appeals to considerations of equality or rights, one cannot avoid different senses of equality or rights. As we showed in Chapter Two, the three authors in fact advocate different principles of equality and argue for more or less different modes of health care distribution. Similarly, Friedman,
Fried, and Beauchamp and Childress endorse sharply contrasting doctrines of rights and lay out entirely different accounts of social justice in health care.

I. Negative Rights: Friedman’s Economic Account

1. The rights

Friedman holds a utilitarian economic theory. He supports a doctrine of negative rights, not positive rights. Very briefly, negative rights are claims against something, in contrast to positive rights that are claims to something. When X has a right to Y against Z, if this is a negative right, it means that Z has an obligation to X not to deprive X of Y. However, if this is a positive right, it means that Z has an obligation to X not to withhold Y from X or an obligation to provide Y to X. 18 From Friedman’s view, negative rights are the only rights that individuals naturally have.

Friedman terms his account of health care allocation an economic theory. He claims that his theory is based on the explorations of efficiency. Nevertheless, he correctly concedes that such explorations depend on further moral argument, because not all efficient circumstances are preferable. 19 In particular, he claims that his moral position is similar to that defended by Robert Nozick in Anarchy, State and Utopia: “there exist natural rights,” which “can be described in terms of entitlements,” and “to be entitled to something is not the same as to deserve it” (1991, p. 261). Seen from this position, he contends that saying one has a right (as an entitlement) is not making a

18 For a comprehensive discussion of the distinction between negative and positive rights, see John Finnis (1980).

19 By “preferable” I assume he means “morally justifiable.”
complete statement of what one ought to do, but is to advance a claim against others’ performing certain actions on one. For instance, the concept of my right to life “makes sense as my right to have other people not to kill me. It does not make sense as a blank check against the rest of the human race for anything that extends my life” (1991, p. 286). Hence, rights that make sense for Friedman are only negative rights, i.e., rights as “side constraints,” to use Nozick’s terminology.

2. Health care

Like Nozick, Friedman believes that individuals’ negative rights “correspond fairly closely to a pure free market society” (1991, p. 261). From his perspective, such “a pure free market society” is in the best interests of people in the utilitarian sense (p. 261). The same conclusion goes for health care allocation. For Friedman, medicine is and ought to be a commodity that people can sell and purchase in the free market. The benefit of government interventions in health care allocation is at best very suspect. For him, “health care should be provided entirely on the private market, just as shoes and potato chips are now provided” (pp. 301-302). Regarding the claim that “health is too important to be left to the market,” Friedman’s response is that

the market is, generally speaking, the best set of institutions we know of for producing and distributing things. The more important a good is, the stronger the argument for having it produced by the market (p. 302).

In short, from Friedman’s perspective, individuals have a (negative) right to health care in the sense that they can freely purchase or sell types of health care as they wish. They
do not have a (positive) right to health care in the sense that the state should ensure a certain level of health care to them.

3. Justification

Friedman argues that there are only two major sorts of economies: government-run economies and private-run economies. Since government can be seen as "a shorthand description for a mechanism - a set of rules - under which individuals interact in order to achieve individual objectives," government-run economy can be viewed as merely a second and different market, "a political market in which exchanges occur and decisions are made under a different set of rules" from that in the private market (1991, p. 260). So the private market is a market in which production, allocation, and regulation are based on basic market laws; while the political market is a market in which production, allocation, and regulation are arranged by government. The question for Friedman is whether medical services should be done entirely in the private market, or entirely in the political market, or by some combination of the two.

Friedman supports the entirely private-market running of health care. His argument for it can be summarized in the following steps:

(1) The only rights that individuals have are negative rights;

(2) The negative rights require a private-market society in which everything should be done through the private-market mechanism rather than the political-market mechanism, insofar as the private-market mechanism is more efficient than the political-market mechanism;

(3) Health care allocation through the private-market mechanism is more efficient
than through the political-market mechanism;

(4) Therefore, health care allocation should be undertaken through the private-market mechanism.\(^{20}\)

Friedman does not attempt to offer any systematic argument the doctrine of negative rights that he supports. In one place he offers arguments for a right to private property based on the Lockean assumption that each person owns his own body, (1983; 1989, #1). Specifically, he believes that there exist two facts that make private property necessary: first, "different people pursue different ends," and second, "there exist some things which are sufficiently scarce that they cannot be used by everyone as much as each would like" (1989, p. 4). Accordingly, the institution of private property is both inevitable and beneficial.\(^{21}\) In short, Friedman does not offer much argument for his premise (1).

Regarding premise (2), Friedman does not argue why the negative rights require a private market society. He simply claims that "the rules of original entitlement and transfer that I find plausible correspond fairly closely to the laws of a pure free market society" (1991, p. 261). This makes us suspect that he accepts Nozick's argument for a

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\(^{20}\) This is my summary of Friedman's position according to my understanding of his argument. He seems to argue for two independent points: (1) the doctrine of negative rights corresponds fairly closely to a pure free market society, and (2) a free market society is more efficient than a political market society. I attempt to bring these two points together to make a coherent argument in order to make his entire theory cohere with his claim that "arguments based on efficiency... depend on further moral arguments" (1991, p. 261). Friedman never offers a clear argument for why individuals have negative rights. Presumably, as a utilitarian, he should have argued that these rights should be established because they maximize individuals' interests.

\(^{21}\) This argument seems in essence to be utilitarian. Both facts he mentions imply that the establishment of a right to private property will maximize individuals' ends and desires.
minimal state. But this is not the case. Friedman explicitly states that he argues for “Anarcho-Capitalist-Libertarianism.”

The second part of premise (2) (“everything should be done through the private-market mechanism rather than the political-market mechanism insofar as the private-market mechanism is more efficient”) is necessary to his argument, from my perspective. It is in principle imaginable that, in an overwhelmingly private-market society, a political-market arrangement for some peculiar items may not violate any individual’s negative rights (for instance, people may agree to the government arrangement of some particular item). In this situation, why should we still prefer the private market? For Friedman, we should choose the market that is most efficient in the economic sense. It is only in this way that we can make sense of Friedman’s following statements:

I suspect, although I cannot prove, that market arrangements are so much superior to any workable alternative that most people, including most non-utilitarians, would prefer their consequences to those of any alternative. If I am right, then political disagreement is fundamentally a disagreement about the economic question of what consequences different institutions produce, not the ethical question of what consequences we prefer (1991, p. 264).

For Friedman, although only utilitarians contend that utility is all that matters, ethicists of all kinds agree that utility is among the things that matter. Since efficiency is an approximation of utility, and since the difference in efficiency among different institutions is large, individuals will not disagree about which consequence is better and

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22 In Part III of his 1989, he defends his account of anarcho-capitalism.
thus should be preferred (an ethical question). Instead, individuals may disagree about what consequences different institutions will produce (an economic question). This is why he claims that political disagreement may mainly involve the economic question rather than the ethical question. This is not because the economic question is more fundamental than the ethical question. Rather, for Friedman, the ethical question is already clearly answered by the utilitarian considerations of utility and efficiency. Only the economic question of which market produces the most efficient result is left.

Step (3) constitutes the crucial part of Friedman’s theory of healthcare. This part is worth particular attention. To begin with, Friedman accepts a traditional understanding of the concept of efficiency: a situation is efficient if it cannot be Pareto-improved; whereas a Pareto-improvement is a change that benefits someone and injures no one. However, he prefers a slightly different approach to the concept:

I define an improvement as a change such that the total benefit to the gainers, measured by the sum of the numbers of dollars each would, if necessary, pay for the benefit, is larger than the total loss to the losers, similarly measured. I call this a Marshall improvement. I define a situation as efficient if it cannot be Marshall-improved (p. 262).

Accordingly, saying that the private-market health care is more efficient than the political-market health care means that, compared to the political-market health care, the private-market health care is at least closer to a situation that cannot be Marshall-improved. In order to demonstrate this belief, Friedman employs a strategy of dealing with the cases in which there are apparent failures of the private market. He argues that even in such apparent failures of the private market, private-market health care is still
more efficient than the political-market health care. Accordingly, he concludes, people
should prefer a private-market pattern of health care allocation in all kinds of situation.

The first case of apparent market failure involves *imperfect information*. The
information that we get on the quality of medications, the skills of physicians, the
services of medical institutions, the side effects of treatments, and so on, is very
imperfect. Therefore,

our willingness to pay for drugs or services reflects only very approximately their
real value to us, hence providers of goods and services may find it in their interest
to provide them even when real benefit is less than their cost, or not to provide
them even when it is greater. In either case we have an inefficient outcome (p. 290).

Government solutions to this case include licensing physicians and regulating drugs.
Under such government solutions, unlicensed physicians are prohibited from practicing
and drugs are kept off the market until the FDA has approved them. The outcome is that
medical licensing holds down the number of physicians and holds up their salaries.
There is extensive evidence, Friedman argues, that “the American Medical Association
has used medical licensing for this purpose, in some cases supporting requirements, such
as U.S. citizenship, that made more sense as ways of restricting entry to the profession
than as ways of maintaining quality” (p. 292). Consequently,

Government regulation of barbers make haircuts more expensive; one result,
presumably, is that we have fewer haircuts and longer hair. Government
regulation of physicians makes medical care more expensive; one result,
presumably, is that we have less medical care and shorter lives (p. 302).
In the case of government regulation of drugs, the situation is even more problematic:

If the FDA licenses a drug that turns out to have disastrous side effects, the result is a front page story and the end of the career of whoever made the decision. If it refuses to license a useful drug, the result is to keep a cure rate from rising - say from 92% to 93%. The total cost may be very large, but it is not very visible, so that the FDA may have a strong incentive to be overcautious, possibly with lethal effects (p. 293).

In fact, Friedman argues that such regulation can cause mass murder. He gave the example of the FDA’s preventing of the use of timolol, a beta-blocker for over a decade. The consequence of this prevention, he concludes, is the death of a hundred thousand people with heart-disease (p. 293). 23

Hence, Friedman argues, the case of imperfect information only suggests that government should provide information on services and drugs (like labeling of cigarettes) and offer certification for physicians. It should not license physicians or regulate drugs. Consumers should be left with their own free choices, because they have superior information about their own values (pp. 291-292). For Friedman, as long as there is no coercive intervention from government, there can be a number of market solutions to the problem of imperfect information. First, individuals can join an organization better informed than the individual consumer: for instance, buying health insurance and allowing the insurance to provide expert advice. Second, individuals can rely on some

23 Friedman uses the word “killed” here (p. 293). Given that it may be reasonable to distinguish active killing and letting die by default in the case in question, I avoid using the word “killing.”
expert body to certify the quality of drugs or physicians, for example, the Underwriter's Laboratory. Finally, individuals can pursue guarantee or liability offered by drug companies or physicians, insofar as they are willing to pay more for such guarantee (pp. 290-291). In short, even in the case of imperfect information, Friedman argues that the private-market solution is more efficient than the political-market option.

The second case that suggests the failure of the free market in health care allocation involves imperfect competition. Imperfect competition generates problems especially in sparsely populated areas, where drug supplies, physician services, and medical institutions are easy to form monopolies. Since such monopolies may not charge efficient prices, many would think that government intervention would produce improvement. However, Friedman proposes two major reasons that do not support government intervention. First, in order to make effective regulation, the government must know the cost curves of the regulated firms - how much it cost to produce any level of output - and the demand curves of consumers. But this is difficult to know. It is particularly difficult to know "in an industry such as medicine, where quality variables are important and hard to measure" (p. 298). Second,

Regulation has the additional disadvantage of providing the industry with a tool that may be used to maintain a monopoly position that would otherwise be eliminated by technological change (p. 298).

Namely, the industry may use government regulation to immunize itself from possible competition. Hence, in the case of imperfect competition, Friedman also concludes that
the private-market strategy remains more efficient than the political-market arrangement.\textsuperscript{24}

Friedman also considers other cases that seem to suggest that the government should regulate or redistribute health care. A prominent case is the problem of transmit for the poor. The traditional standard utilitarian argument supports redistribution to the poor from the affluent based on the assumption that, for a given individual, the marginal utility of income declines as income increases. Hence, according to such argument, total utility will be increased if the government provides free medical care to the poor at the expense of the rich. Friedman contends that, theoretically, it is not necessarily true that the marginal utility of income is correlated inversely with income; and practically, it is suspicious that government welfare programs actually benefited the poor. Hence, he

\textsuperscript{24} In a widely noticed article, "Uncertainty and the Welfare Economics of Medical Care," Kenneth Arrow lays out several aspects in which health care market differs from the usual commodity markets. First, the need for health care is generally irregular and unpredictable. It may come suddenly, unlike any other item in the average household budget. Second, doctors do not advertise, and there is no open price competition among them. Third, the existence of a medical profession severely limits the supply of medical care, for practitioners must be licensed. Finally, medical care cannot be returned to the seller for a money-back refund; it cannot even lightly be taken back for repairs if it goes wrong; nor can one cut one's losses and throw it away (Arrow, 1963). Presumably, Friedman would argue that the second and third features that Arrow points out are the very products of state intervention in health care market. He would contend that these features should be got rid of health care so that it could be more efficient and thereby more beneficial to patients. As to the last feature that concerns the importance of the quality of health care, Friedman would argue that market competition can contribute to the promotion of the quality much more than government regulation. Finally, many authors, including Singer (1985) and Daniels (1997), underscore the first feature of health care that Arrow states to argue for the claim that health care cannot be left to the free market. For Friedman, this feature, namely, uncertainty caused mainly by irregularity of health care need and imperfect information, does not call for government intervention. Irregularity of health care need suggests that one should join a health insurance plan, rather than relying on government. As to imperfect information, as we show in the text, Friedman argues that this suggests that government should offer information, rather than regulation.
does not support government projects of transmit (p. 282).

Finally, Friedman objects to using moral intuitions concerning particular examples as discussion stoppers. For him, it is easy to pick some unattractive outcome and describe it as "intolerable" or "unacceptable" to attempt to make a conclusion. For instance, many people find the following kind of cases unpleasant: a poor man was turned away from the expensive private hospital that could have cured his disease if he had been able to pay. They try, basing on such a case, to conclude that government must intervene to provide needy health care to everyone. However, Friedman contends that this is "a game that any number can play" (p. 302). For him, it is unreasonable for one simply to rely on the bases of such cases draw the conclusion that a private-market health care is undesirable. The defender of the private market health care can also point out the horrible fate of "the hundred thousand people who died of heart attacks because the FDA refused to permit American physicians to prescribe beta-blockers to American patients" (p. 302). For him, "in any large and complicated society, it is likely that any system for producing and allocating medical - or doing anything else difficult and important - will sometimes produce outcomes that can plausibly be labeled as intolerable" (p. 302).

From Friedman's view, the function of moral intuition is limited in moral reasoning also because our moral intuition, in dealing with a complicated case, is easily distorted by our experiences in dealing with simple cases. He offers an illuminating case in this regard:

Suppose there is some individual who requires - and does not get - a ten million dollar operation to save his life. Further, suppose that ten million dollars is precisely the sum spent, during a year, by all the people in the U.S. in order to
have mint favor in their toothpaste. Surely, this is a monstrous outcome - a man losing his life in order that others can have the trivial pleasure of mint flavor in their toothpaste.

The conclusion seems unavoidable, but I believe it is wrong. The problem, I think, is a fault in my (and I presume your) moral intuition - our inability to multiply by large numbers. To most of us, a number such as two hundred million has only a vague meaning - we have no intuition for how much the importance of a trivial pleasure is increased when it is multiplied by two hundred million. In contemplating the situation I have described, we end up comparing the value of one life to the value of a trivial pleasure to one person, or perhaps a few. Seen that way, the answer appears obvious (p. 285).²⁵

Here Friedman is saying that we understand a trivial pleasure of two million people is substantially different from a trivial pleasure of one person or a few persons. But we do not have ability to multiply by large numbers. When we compare a trivial pleasure of one person to one life, we have clear intuition about the difference of their respective value. This is a simple case. But when we compare a trivial pleasure of two million people to one life, we are not able to form any clear intuition. This is a complicated case. We simply use the intuition we formed in experiencing the simple case to construct our intuition in the complicated case. That can be misleading.

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²⁵ In his paper Friedman mainly uses this example to argue against the claim that life is infinitely valuable in comparison to other things. I find the example also useful to show the limited function of our moral intuition in moral reasoning. This case-analysis constitutes a good lesson to us in using our moral intuitions to build a moral argument and to draw a particular conclusion - we must be aware of the inevitable limitation of our moral imagination manifested in our intuitions.
To sum up, many argue that even if the free market is generally preferable for the most case, there are cases in which the free market mechanism fares poorly and government intervention is required. Such cases, for them, can easily be found in health care allocation because of the specific features of health care. Friedman analyzes these cases where free-market solutions apparently fail. He concludes that the private market remains preferable to the political market even in these cases. Hence, from his view, health care allocation ought to be run entirely through a free market mechanism.

4. Critique

The major problem with Friedman's theory is that it lacks an adequate justification for its doctrine of negative rights. He advances a wide range of considerations to defend the efficiency of the private-market running of health care thereby making his theory vulnerable to attack from non-economic considerations. For instance, Friedman must confront a critique such as: "we understand your argument is that the private-market health care is efficient. Even if we assume you are right in this, this is not the whole story. A perfectly private market will definitely leave some poor people without health insurance. They will suffer and die because they cannot afford health care. What are we going to do with them? Is it not morally appropriate for government to provide some health care, even if such government intervention will compromise some economic efficiency? Why should we always care about efficiency? After all, you have agreed that arguments based on efficiency depend on further moral arguments."
Presumably, Friedman will answer that individuals have only negative rights, not positive rights. One’s right to health care is a right by which one can freely purchase or sell medical services. It is not a right to be offered health care by others free of charge.

But why do people only have negative rights? Many believe that people also have positive rights, such as a right to be helped in medical situation.26 Friedman must provide an argument for his doctrine of negative rights in order to defend his entire theory. Without such a justification, no matter how well his defense of the efficiency of the private market may be, his account is defective. As he admits, “there are some circumstances in which an inefficient outcome is preferable to an efficient one” (1991, p. 261). Many people believe that health care is such a circumstance.

Presumably, as a utilitarian, Friedman would offer a utilitarian defense for individual rights. He might argue that individuals have negative rights because these rights maximize individuals’ total utility. On the other hand, individuals do not have positive rights because if such rights are established, it would decrease, rather than increase, individuals’ total utility. However, such an argument could be challenged by asking why we should only or always care about total utility? Again, even if we agree that only negative rights will maximize total utility, we could still consider why not also pursue average utility or outcome equality?

II. Positive Rights: Fried’s Deontological Account

26 For example, in his 1988, Baruch Brody defends an account of positive rights relating to health care.
1. The rights

Fried’s doctrine of rights includes both positive and negative rights. According to him, “a positive right is a claim to something - a share of material goods, or some particular good like the attentions of a lawyer or a doctor, or perhaps the claim to a result like health or enlightenment - while a negative right is a right that something not be done to one, that some particular imposition be withheld” (1979, p. 110). Negative rights include personal rights (freedom of movement, freedom of speech and development of one’s talents, sexual freedom, the right to privacy), political rights (the right to vote and to participate in government), and legal rights (such as the right not to have one’s liberty or property interfered with by the state except according to the process of law) (pp. 133-134). The principal positive right is the right to a fair share of society’s scarce resources (p. 110).

Fried contrast his doctrine with both consequentialism and libertarianism. According to him, the consequentialist wants individuals to look only to the end state reached or aimed at, and the libertarian contends that rightness depends only upon individuals’ not getting in each other’s way as they proceed, whereas his doctrine assumes that “rightness depends on the pursuit both of fairness, compassion, and thus on a (loosely identified) end state, and also on respect for the absolute constraints of negative rights” (p. 162, italics original).

Fried holds a deontological moral theory. His doctrine of rights is deontological in nature. Its primary concern is not about the avoidance of pain or the increase of the good in the world. Rather, it is about right and wrong. As he states,

Our first moral duty is to do right and to avoid wrong. We must do no wrong - even if by doing wrong, suffering would be reduced and the sum of happiness
increased. Indeed, we must not do wrong even in order to prevent more, greater wrongs by others (p. 2).

He states that his theory is primarily Kantian (p. 118).

2. Health care

There is a significant change in Fried’s view on health care allocation between his early and late positions. On his early view (1976), everyone has a “right to a decent minimum” of health care based on everyone’s basic needs. “The decent minimum should reflect some conception of what constitutes tolerable life prospects in general” (1976). And only “a decent minimum” should be equally guaranteed because, he noticed, a right to equal access to all or best health services would drain social resources. Accordingly, for Fried, market forces must be allowed to determine access to health services beyond the minimum.

In his late doctrine (1979), he drops his early defense of a “right to a decent minimum” of health care. He recognized that the account of an equal right to decent minimum of health care would face the same intractable difficulty as the account of an equal right to all or best health services. Even if we only want to ensure the satisfaction of very basic needs or a “decent minimum” of needs for everyone, then our efforts to satisfy our most unfortunate fellow citizens’ medical needs could cause a drain on resources which would leave few resources available to satisfy other kinds of needs (education, defense, housing) of healthy, secure, educated persons. The medical needs of our most unfortunate fellow citizens can be extraordinary expensive needs, but extraordinary needs may still be very basic medical needs, whatever a definition we give
to such needs. "There is always the possibility of devoting endless research funds to the development of relief measures which do not now exist" (p. 122). Hence, ensuring such needs would inevitably "open the potential for excessive demands by those with extraordinary needs" (p. 127). For Fried, it would be absurd to argue that everyone's basic medical needs ground a right to their satisfaction and then go on to say that the measure of such a right "is a fair share only of effort to meet those needs" (p. 122). However, if we really mean what we argue for a right to decent health care, we will be caught in a different type of absurdity. For example, consider the financial costs involved in saving the lives of severely defected newborns or in preventing any "premature" death in medical care. Indeed, "there is literally no end to the drain on resources that medicine might represent if we consider the various ways of prolonging life and restoring function which might be developed should we choose" (p. 122).

Accordingly, in his later doctrine, rather than trying to defend a positive right to any basic health care, Fried argues for a principal positive right. This is a right that Fried believes everyone has against those with whom one lives in general communities (cities and states): "a right to a fair share of that community's scarce resources" (p. 110). According to Fried, the object to which the fair-share formula is applied should not be basic needs, or particular goods, or results, or wants. It should be money (pp. 126-127). "This transfers the whole burden of the argument to the determination of a fair distribution of income" (p. 128):

If I have a fair income, then I can save against medical need or I can purchase insurance with whatever benefit ceiling I choose, subject only to the constraint which my total income has placed on my ability to pay premiums. If I am
someday denied some incredibly expensive therapy because its costs exceed my benefit ceiling, I cannot complain: I had during my healthy years made a deliberate choice to spend my share of resources to other things - housing, amusement, education, charitable contributions - so that now that the consequences of my choice have come home to roost, I should not be able to welsh on my bargain (p. 127).

Hence, Fried insists on a general positive right to resources. He does not advocate any positive right to health care. He advocates reliance on the insurance mechanism to provide health care allocation.

3. Justification
Fried is not an intuitionist. He does not intend that his theory be deduced from some set of self-evident principles. Instead, he claims to defend his theory by virtue of its richness and overall plausibility (p. 118).

For Fried, right and wrong are directive concepts. They are expressions of respect for persons independent of the evaluation of the states of the world (p. 9). The concept of wrongs offers a way of looking at moral phenomena from the point of view of the actor. For instance, it is wrong to harm an innocent person even if such wronging may bring about a good result. The concept of rights considers the same moral phenomena from the point of view of the victim - an innocent person has a right not to suffer intentional harm. "A claim of right blocks the appeal to consequences in justifying violations of a right, just as such an appeal is blocked in the case of wrongs" (p. 81).
Fried does not contend rights to be absolute. He concedes that there are extreme situations (for instance, the catastrophic) in which rights claims no longer apply (p. 10). Instead, rights are categorical in the sense that their application is not contingent upon the agent’s adopting some other independent end, such as a good outcome. Hence, Fried accepts Kant’s distinction between categorical and hypothetical imperatives (pp. 11-12). However, even as a categorical norm, a right may be overwhelmed by extreme circumstances. “But as long as the consequences fall within a very broad range, the categorical norm holds, no matter what those consequences” (p. 12).

Indeed, Fried begins to defend his theory of rights by refuting the economic analysis of rights. The economic analysis of rights assumes that the function of a legal system of rights and liabilities is to promote economic efficiency, that is, to simulate the outcomes of bargaining in the absence of transaction costs. Thus rights are not independent moral constraints, but devices for attaining efficiency (p. 93). Accordingly, as long as there is no difference on the attainment of efficiency, it does not matter how rights are accorded. If maintaining A’s right to X against B produces the same achievement of efficiency as maintaining B’s right to Y against A, then consequentialist view of rights is indifferent to the two strategy of maintaining (pp. 86-91).

In sum, the economic perspective sees human relation as a relation of exchange. Exchange involves bargaining. Hence, the economic perspective of rights views rights as useful devices in terms of their tendency to produce efficient results in the bargaining process of exchanges between individuals. This perspective sharply contradicts Fried’s nonconsequentialist, categorical conception of rights. For Fried, the most illuminating aspect of the economic analysis of rights (and any consequentialist conception of rights)
is that "no interests (not our lives, not our safety, our land, our ideas, our labor, our teeth, our kidneys) can be taken for granted as naturally ours" (p. 100). Unless the process of bargaining wins them for one, one's oranges, land, house, car, and finally, even teeth are not one's own. However,

if, therefore, there is no basis for assuming, apart from the outcome of that process, that taking a man's teeth or twisting his arm is an interference with the bargaining relation (instead of simply just the exercise of it), then what is exempt from bargaining? Here ... we come to an impossible dilemma: either what is called bargaining is in fact simply a description of how people behave (and why just people? Why not tigers, sugar crystals, and electrons?) or some freedom from unconsented-to imposition must be assumed as a privileged starting point, a background against which the very concept of bargaining is defined (p. 103, italics original).

For Fried, this shows that the consequentialist analysis of rights fails to offer a complete account of rights. This is because it does not have a complete conception of the person. Under such consequentialist accounts, "the person finally becomes an abstract point, to which pleasure and pain may be attributed, but with no dimension or shape of its own" (p. 104). For Fried, the parties to the bargains must be assumed to start from some position of security. "If their land is not their own, then surely their house, or their body, or their teeth are their own" (p. 103). Hence, Fried claims that his theory of substantive rights "is elaborated from the concept of the person and what is necessary to establish the integrity of the person" (p. 105).
Fried’s concept of the person includes a clear conception of a nonconventional property right. Although he does not address this issue in his 1979, he states it in 1981: our persons (and thus our physical persons) are not available to the used by others against our will. ... not all property is conventional. The grounds for recognizing a (property) right in one’s own person, talent, and efforts are nonconventional in the sense that they are part of moral theory - liberal individualism, but other moral theories as well - and so depend not on arguments of social expediency but on the truth of the moral theory. ...Some political theorists like Adam Smith and Friedrich Hayek argue that collective goals are in fact best achieved by enlisting individual initiative through a regime of rights. I am not persuaded that this is so, ...Indeed, to withdraw all relations to things from the regime of rights would render largely nugatory the natural right to one’s own person and efforts, for those efforts are expended on the outside world (pp. 99-101).

From Fried’s view, property and contract may not necessarily be efficient or beneficial to collective goals. But they are rights (1981, p. 152, note 20). It is the substantive content of the norms of rights that expresses our respect for personality. “What we may not do to each other, the things which are wrong, are precisely those forms of personal interaction which deny to our victim the status of a freely choosing, rationally valuing, specially efficacious person, the special status of moral personality” (1979, p. 29, italics added). The language of rights is not based on care about efficiency or utility. It is respect for the status of our moral personality.
For Fried, respect for our status of moral personality requires respect for our physical integrity. This is because our physical body is our private property. We have a right to our body in the sense that it cannot be used for whatever purposes against our will. Thus, it is a violation of right to take my kidney against my will. It is equally a violation of right to take my kidney against my will and pay me for it (p. 141). Accordingly, from Fried’s view, the fashionable proposition that no one is entitled to the benefit of unearned natural advantages is morally problematic. If we are serious about this proposition, “so that the more fortunate should contribute to the situation of the less fortunate, what could be a clearer obligation than to enter, say, a lottery, the ‘winners’ of which would be compelled to donate just one of their kidneys?” (p. 140). For Fried, we have a negative right not to be compelled to donate our organs.

Consequently, Fried holds a clear view of property right to one’s body, one’s natural advantages, and other external things that one owns. It is against the right to use them against one’s will. However, Fried permits taxation to fund redistribution (p. 143). Some type of redistribution may even be a moral obligation. This is a puzzling requirement in his moral system. Of course, compelled tax payment for redistribution is not compelled donation of one’s bodily parts. But is that not compelled donations of one’s talents, efforts, and labor? Given that Fried contends one has a property right to these items, how is he to argue for redistributive taxation against one’s will without violating the right?

Fried believes that respect for persons not only grounds our negative rights, but also grounds “affirmative obligations” (p. 115) as Kant argues in his *Grounding for Metaphysics of Morals* (Kant, 1959, 424). He bases his position on Kant’s arguments to
justify his system of positive rights. For him, as for Kant, "the facts of mutual independence and common humanity make it unreasonable to adopt a principle of indifference to the situation of others" (p. 115). He believes that Nozick’s doctrine of rights only as side constraints is exactly the one which Kant considers but rejects (p. 117).²⁷ As he states,

The fact of our common humanity is so pervasive that to speak of obligations of debt and of gratitude to our fellow men is too weak. ...There are aspects of common humanity which we share because of the efforts of others to produce them: the fruits of common labor, the security of civil society, the riches of culture and civilization, the fact of language. These things bind us together not only because, like our bodies, we all have them and thus are enabled to recognize

²⁷ In his *Grounding for the Metaphysics of Morals* (1981), Kant argues for the universal imperative of duty. As is well-known, one expression of the imperative is the following: “Act as if the maxim of your action were to become through your will a universal law of nature” (p. 30, 421). Based on this imperative, Kant explores four types of moral duty that everyone has: perfect duty to oneself, perfect duty to others, imperfect duty to oneself, and imperfect duty to others. He concedes that one’s duty to help others in need is only an imperfect duty, “imperfect” in the sense that not performing this duty does not involve any conceptual contradiction. Moreover, human society could subsist without this duty and could subsist even better than “when everyone prates about sympathy and benevolence... but, on the other hand, also cheats when he can” (p. 32, 423). However, Kant contends that although human society can survive without this duty, no one can really will it in this way. “For a will which resolved in this way would contradict itself, inasmuch as cases might often arise in which one would have need of the love and sympathy of others and in which he would deprive himself, by such a law of nature springing from his own will, of all hope of the aid he wants for himself” (p. 32, 423). Accordingly, Kant’s argument for a duty to help others in need is based on the consideration of contradiction in will.

However, as the subsequent citation of Fried shows, Fried’s argument for a positive right to the community’s resources seems different. His consideration is not based on human will. Rather, it is based on the share of common humanity and the contribution of others to the community. In this sense, Fried’s argument is not exactly Kantian.
our fellows through them, but also because others have expended their energy in order to produce them for us. They bind us because they oblige us. They are the basis of positive claims. Thus it is inconceivable that respect for common humanity should compel the recognition of the negative rights of our fellow men even at disastrous cost to ourselves, while leaving us totally indifferent to their needs - needs which may be desperate and which we may easily be able to alleviate (p. 118).

This consideration, for Fried, leads to our principal positive right against our community: a right to a fair share of our community’s scarce resources (p. 110). Naturally, this right corresponds to our principal duty to contribute (p. 147). He seems to argue that, because everyone contributes to the community (in particular, “aspects of common humanity which we share), everyone should have a right to share its resources. Moreover, since we have this right, we have a corresponding duty to contribute, to do our part. Fried contends that individuals can make this contribution through paying tax. The ideal tax, from his view, should be a consumption tax. “A consumption tax is intended to express the idea that a man should contribute in relation (however the proportion is defined) to what he takes out of the pool of scarce social resources” (p. 147, italics original).

Fried believes the consumption tax has significant merits. First, it respects individual choices, “because its incidence falls only on what a person chooses to do, not on what he might do - as would a tax on capacities, talents, or dispositions” (p. 148). Second, it does not carry the problem of income tax. “The income tax is troublesome because it requires a contribution in terms not of the individual’s withdrawals from the pool of social resources but rather in terms of what he contributes to that pool, for a
man's income (in a well-functioning economy) should reflect the value of his services, so that a person receiving a higher income is making a more valuable (or valued) contribution” (p. 148).

4. Critique
Fried's argument for his system of both negative and positive rights is inconsistent in virtue of his principal positive right. On the one hand, he argues that one has a negative (property) right to the talents, capacities, and energies that one naturally possesses. It follows, according to Fried's own logic of negative rights, that no one has moral authority to take another's talents, capacities, or energies without another's consent (call this conclusion A). On the other hand, however, he argues that everyone has the principal positive right to a fair share of a community's (state or city) scarce resources. It follows, in his system, that everyone has a compelled obligation to contribute in terms of his consumption. It follows again that the community has moral authority to levy a consumption tax on everyone against his will for redistributive purposes. Since one's resources used for consumption are the product of one's talents, capacities, and energies, it follows that the community has moral authority to take some of the product of one's talents, capacities, and energies against one's will. Since taking the product of one's talents, capacities, and energies against one's will is in a significant sense equivalent to taking one's talents, capacities, and energies against one's will, it follows that the community has moral authority to take one's talents, capacities, and energies against one's will (call this conclusion B). Now Fried's system arrives at both conclusion A and conclusion B, but they are contradictory.
Which step in my critique is Fried going to challenge in order to maintain his position? Most probably it is the step about the equivalence between taking the product of one’s talents, capacities and energies against one’s will and taking one’s talents, capacities, and energies against one’s will. Fried might well argue that they are significantly different. Again, as we quoted him previously, Fried emphasizes that

There are aspects of common humanity which we share because of the efforts of others to produce them: the fruits of common labor, the security of civil society, the riches of culture and civilization, the fact of language. These things bind us together not only because, like our bodies, we all have them and thus are enabled to recognize our fellows through them, but also because others have expended their energy in order to produce them for us. They bind us because they oblige us (p. 118, italics added).

Suppose that here Fried is saying the following. There is a significant difference between one’s talents, capacities, and energies on the one hand and the product of one’s talents, capacities, and energies on the other. It is true that one has a categorical (property) right to one’s talents, capacities, and energies. No one else has a right to use them against his will, just as no one else has a right to use one of his kidneys against his will. However, the product of one’s talents, capacities, and energies is different. The product is never produced exclusively by one’s own talents, capacities and energies. Instead, it is always based on social bases which the efforts of others have contributed to form (such as “the fruits of common labor, the security of civil society, the riches of culture and civilization, the fact of language”). Therefore, others have contributed to the formation of the
product. Hence one does not have a categorical (property) right to the product of one’s talents, capacities and energies. The society is entitled to part of the product. This is to say, although the society does not have moral authority coercively to use his talents, capacities, or energies because one owns them entirely, insofar as one voluntarily uses them and forms a product, society has the moral authority to share some of the product, because one never produces it by oneself alone. Therefore, when that product is sold, the purchaser must pay the society for society’s common contribution to the product.

However, if Fried would take this direction of argument, he would face a further challenge to his insistence on the categorical right to one’s body, talents, capacities, and energies. If we cannot own our product entirely because it cannot be produced entirely by us, then we cannot own our bodies, talents, capacities, or energies entirely because these also are not produced entirely by us. They are originally given to us by our parents. Our teachers have contributed to our talents and capacities in a great deal. Finally, farmers have helped us tremendously in producing our food. Following this line of argument, we would not have a categorical right to our bodies or energies as Fried argues that we have. As a consequence, we may legitimately be compelled by society to donate one of our kidneys. We may legitimately be forced to labor for a communitarian cause. This leads exactly to the problem of the “abstract person” from which Fried believes the consequentialist suffers. This is a too big price for a deontologist like Fried to pay.

Indeed, compared to the income tax, the consumption tax that Fried proposes has significant merit. Its focus is on the point that one should compensate society in terms of one’s using society’s scarce resources, unlike the income tax where it seems that one should compensate society because one contributes to society (“for a man’s income
should reflect the value of his services," as Fried points out). However, the merit is quite limited. For one thing, it is not all easy to distinguish consumption from investment. Which acts count as consumption so that they should be taxed? And which acts are qualified as investments so that they should not be taxed? These are very difficult questions. Moreover, part of everyone's income must be spent in consumption to support one's life. This is simply inevitable for any human individual. Consequently, there is a portion in everyone's income that one has to spend in consumption to maintain one's life. One does not have choice in this respect. Hence, to tax this type of consumption is equivalent to tax income to which Fried objects. Given these two problems, the apparent merit of Fried's consumption tax looms dim.

III. The Right to a Decent Minimum of Health Care:

Beauchamp and Childress' Mid-level-principle Account

1. The right

In their most recent version of *Principles of Biomedical Ethics* (1994), Beauchamp and Childress identify their bioethical theory as a principle-based, common-morality theory. As is well-known, their theory presents four principles: the principles of autonomy, nonmaleficence, beneficence, and justice. They claim that these principles have their origins and content in ordinary shared moral beliefs. They hold that these principles are usually accepted by rival ethical theories. “Although not the most general principles in many normative theories, the principles are nonetheless accepted in most types of ethical
theory" (p. 100). In this sense, their principles are supposed to be mid-level principles (pp. 100-106).

Beauchamp and Childress doubt that it is possible to establish a bioethical theory in the sense of not merely an unconnected group of coherent principles and rules. "Perhaps," they state, "mid-level principles, polished analyses of the moral virtues, and coherent statements of transnational human rights are all that should be attempted" (p. 109). From their perspective, affiliation with one type of theory is not always the best strategy in either general ethics or biomedical ethics:

We stand to learn from all... theories. Where one theory is weak in accounting for some part of the moral life, another is often strong. Although each type of theory clashes at some point with deep moral convictions, each also articulates norms that we are reluctant to relinquish (p. 111).

For them, the starting point of morality is a set of deep moral convictions and considered judgments that are accepted initially without argumentative support (p. 24). Hence, they do not endorse the project of seeking out the best theory and rejecting the others whenever several competing theories or systems of belief are available. As they see it, there is a convergence across competing theories. Specifically, many different theories lead to similar action-guides and public policies. Even if theoretical conflicts remain, this practical convergence is encouraging to practical ethics (pp. 109-111). Accordingly, Beauchamp and Childress want their loosely-organized theory of mid-level principles to constitute a mid-level bioethical theory among incompatible and competing bioethical theories. It is supposed to offer practical assistance in shaping moral solutions to actual bioethical issues.
Regarding the issue of social justice in health care allocation, Beauchamp and Childress argue that the project of incorporating some moral concerns stressed by each of competing theories leads to a two-tiered system of healthcare allocation, which includes a right to a decent minimum of health care. As we showed in the last section, this is the very right that Fried advocated in his early work (1976) and rejected in his late work (1979).

2. Health care

For Beauchamp and Childress, the decent minimum approach entails acceptance of the two-tiered system of health care. In the first tier, government enforces universal access to basic health services based on needs. In the second tier, individuals are allowed to purchase better services on their own expense. For them, the first tier would presumably cover “at least public health measures and preventive care, primary care, acute care, and special social services for those with disabilities” (p. 356).

3. Justification

Beauchamp and Childress concede that different, competing theories of social justice lead to distinct patterns of health care allocation. The popular examples of these theories are egalitarianism, utilitarianism, communitarianism, and libertarianism. They suspect that it is unlikely that there will soon be a single viable account of distributive justice. Reflecting on this theoretical and practical reality, Beauchamp and Childress make a series of interesting observations. First, each theory has both advantages and
disadvantages in its practical application. It works well in some contexts but yields disastrous results in others. This suggests that it is inappropriate to adopt one of these accounts as the sole basis for justice in health care (p. 357).

Second, theoretical disagreements may not ultimately make a practical difference. For instance, from their perspective, regarding health care allocation libertarians disagree with them only in the theoretical matter of moral grounding. For them, it is a matter of justice to ensure a right to a decent minimum of health care. But for libertarians, as they see it, “it is virtuous and ideal from the moral point of view, but not strictly a matter of justice, to provide collective plans of health care” (p. 353). However, although there are such theoretical disagreements, it also turns out that libertarians endorse a morally good outcome in health care identical to theirs. Both libertarians and non-libertarians can agree to support a two-tiered system of health care, with society ensuring universal access to the first tier (p. 353).

Finally, as Beauchamp and Childress see it, we should pursue practical convergence among competing theories in directing public actions and policies in health care allocation. They believe that the proposal of a two-tiered system of health care, including a right to a decent minimum of healthcare, “has the advantage of holding out the potential for compromise among libertarians, utilitarians, communitarians, and egalitarians, because it incorporates some moral concerns stressed by each of these theories” (p. 356):

Utilitarians should find the proposal attractive because it serves to minimize public dissatisfaction and to maximize social utility, without demanding unduly burdensome taxation. It also permits allocation decisions based in part on such
formal techniques as cost-effectiveness analysis. The egalitarian finds an opportunity to use an equal access principle and to see fair opportunity embedded in the distributional system. The communitarian perspective, too, is not neglected. A social consensus about values, even if only rough and incomplete, is required for a practical system. The common good is a basic point of reference for public deliberation about how to establish the decent minimum. Finally, the libertarian sees an opportunity for free-market production and distribution. The two-tiered system provides indigents with opportunities for health care that would otherwise not be available to them, and various forms of competition and incentives may be used as tools to increase the system's productivity and the quality of health care (pp. 356-357).

In addition, Beauchamp and Childress argue that the two main arguments that are usually used to support a right to health care turn out to endorse only a right to a decent minimum of healthcare. The first argument is based on collective social protection. According to this argument, threats to health are relevantly similar to threats presented by crime, fire, and polluted environment. If people usually take collective actions and use collective resources to resist the latter threats, they should likewise take collective actions to deal with the former threats. In fact, many public schemes to protect health already exist, including programs of environmental protection and sanitation. A problem is, Beauchamp and Childress notice, that many other public programs involve public goods, such as public health, while health care is largely an individual's private good. Hence, the analogy to collective social protection needs additional elaboration. For them, such premises can be found in our society's investment in physicians' education, funding for
biomedical research, and support for other elements of the medial care system that are distinct from public health and disease prevention. We are entitled to expect a decent return from this public investment. From their view, such a decent return cannot qualify us with universal access to all health services. Instead, this line of argument should support a right to a decent minimum of health care (pp. 351-352).

The second argument is an appeal to the principle of fair opportunity. The major representative of this argument is Norman Daniels that we already dealt with in detail in the last chapter. For Beauchamp and Childress, the difficulty of this argument consists in its causing of drain on social resources. Specifically, Beauchamp and Childress see that “a vast array of disabilities, injuries, and diseases limit opportunity, and many persons are so seriously affected that they could never be restored to a position of fair opportunity, even if immense sums were spent to bring them closer to that ideal” (p. 353). Hence this argument in fact supports only a right to a decent minimum of health care.

4. Critique

Two major critiques of Beauchamp and Childress’ mid-level bioethical theory are naturally in order. First, as we mentioned in the last section on Fried, the right to a decent minimum of health care cannot eschew the same practical problem of the drain on resources from any general right to health care. Given that the scope of a decent minimum is based on basic needs as they intend (p. 356), the problem is intractable. Indeed, even if one provides a modest version of basic needs, this can require spending a vast amount of resources that would make few resources left for others to pursue their healthy or other goals. For instance, no matter how modest a version of basic needs is
assumed for society to guarantee through the means of health care, it should prevent the
unnatural death of human individuals insofar as medically possible (is there anything
more basic for a human individual than saving her life?). Then the society must face the
challenge of preventing pediatric death, early death, and any premature death. If the
society does not only give lip service to their version of basic needs, it must invest
resources in increasing the numbers of hospitals, improving medical facilities, training
special physicians and nurses, adding more ICUs, promoting basic medical research, and
so on and so forth. It is hard to imagine that we can ever reach a point where investing
more resources in medical care will do no more good in preventing human death. Indeed,
as long as more benefits will be achieved, why should we stop investing, given that we
sincerely promised to ensure a basic need for everyone, i.e., saving his life from unnatural
death? Evidently, this will unavoidably lead to the drain on resources.

Second, and more importantly, Beauchamp and Childress’s mid-level theory fails
to take other theories of social justice seriously. In their attempting to locate a practical
convergence of these competing theories, they wipe out the primary practical
implications of each theory. Also, they demonstrate the existence of a practical
convergence among competing theories at the price of the theoretical integrity of each
theory. For instance, on Veatch’s egalitarianism, the crucial idea is that everyone ought
to have an opportunity for a level of health equal as far as possible to the health of others.
This requires the state to offer all important in-kind health services rather than a decent
minimum of health care. On Daniels’ contractarianism, the uncompromising requirement
of social justice is equality of fair opportunity. Health care must be offered to maintain,
restore, or compensate the loss of normal specie-typical functioning. On Singer’s
utilitarianism, the fundamental consideration is equality of interests of all individuals. He strongly believes that only a state-run, single-tier, and all-encompassing health care system is able to satisfy this consideration. On Friedman’s libertarianism, the only defensible rights are negative rights. Accordingly, medicine ought to be a type of commodity sold and purchased in the free market. Finally, in Fried’s deontology, individuals have a principal positive right to a fair share of society’s scarce resources which can support certain monetary compensation to individuals but cannot support any particular right to health care, no matter how minimal. If Beauchamp and Childress were to take the crucial theoretical requirements and primary practical implications of these theories seriously, it would be illusionary to claim that there is such a thing as “a practical convergence” existing among these theories.

IV. A Critical Summary

Friedman, Fried, and Beauchamp and Childress each appeal to a doctrine of rights to account for their views on social justice in general and health care justice in particular. However, they understand the nature of rights differently and argue for different sorts of rights that individuals should possess. Specifically, Friedman supports only negative rights. He contends that individuals should not have any positive right ensured by the state. In contrast, Fried argues for both negative and positive rights. In particular, he insists that everyone has a general positive right to a fair share of the community’s resources, although they do not have any particular positive right, such as a right to health care. Finally, Beauchamp and Childress hold that everyone has a right to a decent
minimum of health care. For them, this right is supported by the common sense morality in society.

They hold different understandings of the nature of rights. As a utilitarian, Friedman must understand rights as maximizing utility or efficiency. In contrast, as a deontologist, Fried regard rights as respect for personality, independent of any consequentialist consideration. Finally, although Beauchamp and Childress together propose the right to a decent amount of health care, they must understand the nature of rights differently, because Beauchamp is a utilitarian, whereas Childress is a deontologist.

Friedman does not offer moral argument for the negative rights he supports. He simply assumes that they exist. On the other hand, Fried affords a detailed account for his principal of positive right to the community’s resources based on an understanding of everyone’s contribution to the community. Although he claims that his argument is Kantian, it turns out that he does not use much of Kant’s strategy. Finally, Beauchamp and Childress offer an argument from convergence for the right to decent health care. As they see it, although utilitarians, egalitarians, communitarians, and libertarians disagree with each other in many ways, they could all agree on the right they propose.

Friedman argues for an entire free market health care allocation. He doubts any net benefit from government intervention in health care allocation. Similarly, Fried also supports entire market approaches to health care delivery through private health insurance. But he argues for a general mode of redistribution through consumption tax that Friedman cannot endorse. Finally, Beauchamp and Childress insist that the state must ensure a decent minimum health care to everyone, whether they are able to purchase luxury health services or not.
A common problem they all suffer is that each fails to offer convincing argument for the doctrines of rights they hold. In the case of Friedman, negative rights are simply assumed for individuals without argument. In the case of Fried, his reason for the principal right to fair share of the community’s resources is in contradiction with his other reason to support his general doctrine of negative rights. In the case of Beauchamp and Childress, their argument for the right to decent health care can be established through theoretical convergence only at the price of distorting the basic senses of major theories of justice. Hence, no one has successfully justified his doctrine of rights as well as its implications for health care distribution.
Chapter Four

A PROCEDURAL ACCOUNT: ENGELHARDT'S PRINCIPLE OF PERMISSION

This chapter introduces H. Tristram Engelhardt, Jr.'s account of social justice in health care distribution. Engelhardt's account is postmodern in his characterization of the

28 The term postmodernity or postmodernism has a variety of references and meanings. In the first place, scholars disagree about when the postmodern age began. Some maintain that postmodernism has been evolving since 150 years. Others contend that originated in the late 1960s and early 1970s. They also disagree whether the modern and the postmodern overlap or are distinct and in what regard (see Rosenau, 1992, p. 5, footnote 4). Moreover, the meanings of the term postmodernity or postmodernism may best be identified by the features of the activities of those who distinguish themselves as postmodernists. As Pauline Rosenau summarizes, first, postmodernists criticize all that modernity has engendered: the accumulated experience of Western civilization, industrialization, urbanization, advanced technology, the nation state, etc. The meaning of postmodernism is thus dependent on the meaning of modernity. Second, they challenge global, all-encompassing world views, be they political, religious, or social. Some of them defend the notion of obligation without justification in a philosophical ethics, of responsibility without the support of ethical foundations (Caputo, 1993). Third, they question the superiority of the present over the past, the modern over the premodern. Fourth, they question any possibility of rigid disciplinary boundaries between the natural sciences, humanities, social sciences, art and literature, between culture and life, fiction and theory, image and reality in nearly every field of human endeavor. Finally, they reject conventional, academic styles of discourse; they prefer audacious and provocative forms of delivery, vital and intriguing elements of genre or style and presentation (Rosenau, 1992, pp. 5-8). In short, it seems accurate to conclude that postmodernism does not open up a new field of artistic, philosophical, cultural, or even institutional activities. "Its very significance is to marginalize, delimit, disseminate, and decenter the primary (and often secondary) works of modernist and premodernist cultural inscriptions" (Silverman, 1990, p. 1). It brings to question everything that modernity cherishes: rationality, egalitarianism, humanism, liberal democracy, causality, necessity, objectivity, determinism, responsibility, and truth (Rosenau, p. ix).

Engelhardt notices at least three denotations of the term postmodernity. First, it may first have been used by Arnold Toynbee to indicate the historical period when reflection takes place concerning the modern age. Second, it was also initially used to identify the massive social, industrial, and technological changes that became salient after World War II. Finally, postmodernity also came to identify both a sociological and epistemological condition: the loss of a universal narrative in terms of which to interpret human experience, along with the recognition of the incapacity to justify or to disclose in general secular terms the content of such a narrative. It is in this last sense, "the absence
contemporary philosophical predicament: no philosophical argument can justify a canonical content-full theory of justice or healthcare justice without begging crucial philosophical questions, i.e., presupposing a specific starting point and/or particular moral or value content that are supposed to be established by reason (1996, p. 8). Given this predicament, Engelhardt argues, no one can establish secular moral authority to impose a particular view of justice or healthcare justice in society. Similarly, government has no moral authority to enforce on everyone a single-tier and all-encompassing healthcare delivery. Multi-tier healthcare distribution is morally inevitable in a large-scale society.

Unlike any of the theorists we have discussed in the previous chapters, Engelhardt does not begin with any substantive principle of equality, doctrine of rights, or normative moral theory. Instead, admitting the cacophonous plurality of ethical and bioethical positions and arguments as an undeniable sociological fact of contemporary society, Engelhardt explores which substantive moral perspective can be justified as canonical and universally applicable and which ethical method can be privileged to do so. However, in order to establish any substantive moral conclusion, one has to begin with certain substantive moral assumptions. Since such substantive moral assumptions are conflicting and incommensurable from one another in contemporary pluralist society, Engelhardt concludes, no substantive moral position can be justified as uniquely true without begging the question, no matter what kind of ethical method one uses. Therefore, any hope of establishing a moral foundation for a general substantive morality must fail. For Engelhardt, what we can reasonably hope is only by default to reveal a moral

as a matter of fact and in principle of a universal secular moral narrative, that Engelhardt identifies his work as postmodern (1996, pp. 20-23, note 7).
foundation for a general procedural morality. This is the origin of his principle of permission. For this reason, it is more accurate to identify Engelhardt’s moral account as a procedural account, rather than a postmodern account.²⁹

I will in order introduce his principle, his view of social justice in health care, his justification for his principle and view of just health care, and finally my evaluation of his account.

I. The Principle

From Engelhardt’s view, contemporary pluralist society should only be governed by a procedural moral principle, namely, the principle of permission.³⁰ Any substantive moral principle, be it regarding human rights or equality or utility, cannot be justified and thus cannot be legitimately applied to the society. His principle of permission, as he sees it,

²⁹ Only with a substantial qualification, Engelhardt can agree with Jean-Francois Lyotard’s diagnosis of contemporary society and culture: “[t]he grand narrative has lost its credibility, regardless of what mode of unification it uses, regardless of whether it is a speculative narrative or a narrative of emancipation” (Lyotard, 1989, p. 37). He would agree with Lyotard that, in general secular terms, no grand narrative can be justified as canonical. But this, for Engelhardt, does not mean that there is no moral limit to the authority “to will the power to play out, listen to, and tell stories” as Lyotard states. Engelardt emphasizes that a general secular principle about moral authority for action can be justified by default. While Lyotard underscores the “non-centrism, non-finality, non-truth,” Engelhardt would limit these features of negativity only to secular narratives (Engelhardt, 1996, p. 22, note 7). Given that Engelhardt still argues that one can offer sound philosophical argument for a common morality, although only a procedural one, he is not a typical postmodern scholar. He still has a foot firmly stepped in the modern intellectual territory.

³⁰ In the first edition of his The Foundations of Bioethics (1986), Engelhardt formulates it as the principle of autonomy. This has generated a great deal of misunderstanding of him as presupposing and cherishing the value of individual autonomy and/or liberty. He reformulates it as the principle of permission in the second edition of The Foundations of Bioethics (1996), making salient its feature as a procedural principle.
lays out a moral procedure regarding the source of moral authority concerning public
decision making and joint action performing. Briefly, in a morally pluralist society, how
can we secure moral authority for public policies or joint actions? Engelhardt formulates
his principle of permission to ground such moral authority. The principle is summarized
as follows:

Authority for actions involving others in a secular pluralist society is derived from
their permission. As a consequence,

I. Without such permission or consent there is no authority.

II. Actions against such authority are blameworthy in the sense of placing a
violator outside the moral community in general, and making licit (but not

Hence, an individual’s permission becomes the only source of moral authority for any
action that involves that individual. For Engelhardt, the public policy implication of
this principle is that permission “provides moral grounding for public policies aimed at
defending the innocent” (p. 123). The innocent are those who do not use force to treat
unconsenting others, even if they do not undertake beneficent actions. The maxim
manifesting the spirit of this principle is: “Do not do to others that which they would not
have done unto them, and do for them that which one has contracted to do” (p. 123). If
one violates this principle in one’s action to others, it is licit for others (though not
obligatory) to use retaliatory, defensive, or punitive force in response. For Engelhardt,

31 Permission may not necessarily be explicit. In fact, Engelhardt distinguishes two types
of permission: implicit consent and explicit consent; both are existent in society.
According to him, a major implicit consent made by everyone in the society is that
“individuals, groups, and states have authority to protect the innocent from unconsented-
to force.” At the same time, he contends, with explicit consent “individuals, groups, and
states can decide to enforce contracts or create welfare rights” (1996, p. 122).
the principle of permission lies at the core of general social morality. It is as inescapable as is the interest of persons in blaming and praising with justification and resolving issues with moral authority. Accordingly, from Engelhardt’s view, healthcare allocation as a public policy or a joint enterprise must be governed by the principle of permission.

Another issue then arises. Who are the moral agents regulated and protected by the principle of permission? All human beings or only some human beings? Only human beings or some other possible beings, too? For instance, in what sense are human fetuses protected by this principle? Should we get permission directly from young children in order to do any thing with them? What does the principle require in our treating adults in the permanent vegetative state? Obviously, Engelhardt needs a general conception of personhood in order to apply his principle of permission. He does provide such a conception. He argues that in order to be a moral agent able to exercise the principle of permission, an entity must meet certain necessary conditions, such as consciousness, rationality, freedom, and a minimal moral sense.32 Under these

32 Engelhardt provides a transcendental argument for a general conception of personhood. A transcendental argument reveals necessary conditions for the possibility of a particular field of human experience or a human enterprise. For Engelhardt, a general conception of personhood can be found in the necessary condition of ethics or bioethics as an intellectual enterprise. The existence of ethics or bioethics as an intellectual enterprise presupposes the existence of certain moral entities with certain necessary characteristics to undertake the intellectual enterprise. In particular, these entities must be self-conscious. They need in addition to be able to conceive of rules of action for themselves and others in order to envisage the possibility of the moral community. They need to be rational beings. That rationality must include an understanding of the notion of worthiness of blame and praise: a minimal moral sense. Sociopaths would cease to be moral agents (persons in the moral sense) only if they lost the capacity to understand blameworthiness to the point that they could not blame those who might injure them. Finally, they must be able to think of themselves as free (Engelhardt, 1996, p. 139, italics original).
conditions, evidently, not all persons need be humans, nor all humans persons. For instance, such humans as fetuses, newborns, the profoundly mentally retarded, and the hopelessly comatose are not persons. On the other hand, if there are non-terrestrial beings, they can be persons if they satisfy those conditions, though they would not be humans. In short, for Engelhardt, the moral agents regulated by the principle of permission are persons, not humans.

These four characteristics, self-consciousness, rationality, a minimal moral sense, and freedom, identify those entities capable of ethical and bioethical behaviors. They constitute the necessary conditions of personhood in the moral sense. Without such moral agents with these characteristics, general secular morality is impossible. Hence, this conception of personhood is “transcendental” in that it constitutes the necessary condition for the possibility of ethics or bioethics as an intellectual enterprise.

As Engelhardt points out,

[n]ot all humans are self-conscious, rational, and able to conceive of the possibility of blaming and praising. Fetuses, infants, the profoundly mentally retarded, and the hopelessly comatose provide examples of human nonpersons. They are members of human species but do not in and of themselves have standing in the secular moral community (1996, pp. 138-139).

This is to say, the moral requirement of permission does not apply to humans who are not persons in the sense of not being moral agents, such as fetuses, newborns, the profoundly mentally retarded, and the irreversibly comatose. For Engelhardt, different moral communities may treat such humans differently, depending upon their respective specific conceptions of personhood as well as their moral visions. However, their particular conceptions of personhood need not be generally accepted, because each of them, unlike the general conception of personhood, is based upon a particular parochial religious or metaphysical position that cannot be justified as universally applicable without begging the question. Accordingly, no person (or government) has the moral authority to impose his (its) own particular conception of personhood on society, either a particular secular, Judeo-Christian, or Confucian conception of personhood, so too no person (or government) has moral authority to impose a particular vision of morality on society. For Engelhardt, the principle of permission along with the general conception of personhood do not constitute a bias in favor of persons, but a recognition of the inevitable characters of a generally defensible secular morality (1996, pp. 140-141).
II. Health care

Engelhardt argues that, as a joint human action, health care allocation must be regulated by the principle of permission. Accordingly, the state does not have moral authority to impose a welfare health care program in society based upon one of particular understandings of social justice. Individuals have a right to health care in the sense that they are free to use their own resources to cooperate with consenting others to provide or purchase types of health care as they see appropriate. They do not have a right to healthcare in the sense that everyone must be guaranteed a certain level of health care through state taxation.

In particular, Engelhardt derives a “principle of health care allocation” from his principle of permission:

People are free to purchase the health care they can buy and to provide the health care others wish to give or to sell (1996, p. 402).

This formulation reminds us of Robert Nozick’s well-known libertarian slogan: “From each as they choose, to each as they are chosen” (1974, p. 160). However, under the principle of permission, healthcare need not be all privately owned or must be run as a commodity. Engelhardt notices that “[t]he principle of permission allows persons with common resources to act beneficently by creating a package of health care that can be guaranteed to others, thus creating basic expectations for care and treatment” (1996, pp. 402-403). For Engelhardt, the core of health care allocation lies in individuals’ voluntary choices and deliberations. His maxim for healthcare goes: “Give to those who need or
desire health care that they, you, or others are willing to pay for or provide gratis (1996, p. 403).

Engelhardt defends a series of secular moral constraints rested in the principle of permission regarding health care distribution. It is helpful to evaluate these constraints one by one to grasp Engelhardt's entire view of justice in health care allocation. First, as Engelhardt sees it, "[a] private tier of health care is morally unavoidable" (p. 403). As long as individuals own private resources in society, they may use these resources to purchase health care for themselves or for their families from those who are willing to offer health services to them. From the principle of permission, they have moral authority to do so, because their actions directly involve only themselves and consenting others. Accordingly, government has no moral authority to prohibit such collaborations. Thus a private tier of health care is morally imprescriptible.

Second, "[a] public or communal tier of health care may, but need not, be created out of communal funds" (1996, p. 403). Individuals voluntarily form and join particular communities. Such communities can be fashioned around thick and intact traditions and

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Engelhardt argues that there are three forms of ownership: private, communal, and general. He provides a Hegelian reinterpretation of Locke's view for appropriating things: one takes possession of things (1) by directly grasping them physically, (2) by forming them, and (3) by making them as one's own (1996, p. 155). However, he contends that one cannot claim to own the matter itself; instead, one should only claim that "the form imposed as an extension of the producer's self is a person's possession in a thing" (p. 157). Untransformed stuff cannot be owned. Hence, taxes may then be collected as a payment due others for the extent to which an individual claiming a particular property through labor diminishes the opportunities of others to claim similar property. Moreover, unlike some scholars who claim such taxation as rent on property should be collected and distributed on a national basis, Engelhardt argues that it should occur at an international level, because objects cannot be fully possessed either by individuals or by particular groups of individuals (nations included). This rent-tax reflects general property rights (p. 158). Finally, legitimate communal ownership comes into existence through individuals' voluntary entry into a joint endeavor with a view to creating a common fund for communal undertakings (p. 160).
practices in which members may cede all they own to the communities (Engelhardt mentions monasteries as an example) (p. 159). Such communities can certainly use their communal resources to provide a type of health care to their members, and thus create a positive right to healthcare within their communities. However, they are not obliged to do so. If they consider other endeavors to be more important than health care for them to invest their resources, they need not offer a communal health care insurance.

Third, "[t]here is no canonical, secularly discoverable normative comparison or ranking of health care needs and desires with other needs and desires, or among health care needs and desires; all such orderings or rankings must be created" (p. 403). Engelhardt notices that individuals have a variety of needs and desires, including health care needs and desires. Because resources that can be used to satisfy their needs and desires are limited, their needs and desires have to be compared and set in an order. For instance, should a society spend resources to provide better housing or better health care when both cannot be achieved at the same time? Within health care, should a focus be placed on high-technology medicine or preventive medicine? Because individuals hold different desires and priorities, and because different communities are committed to different moral visions and values, and because there is no way by sound rational argument to choose among different values without begging the question, Engelhardt argues, there cannot be a canonical normative comparison or ranking of needs and desires in society that can be philosophically discovered. Such orderings or rankings must be created through the voluntary choices of individuals and their communities.

Fourth, "[h]ealth care in all morally defensible circumstances will be multi-tier so that when a basic package is provided for the indigent, more ample or better quality basic
as well as luxury care may be purchased by the affluent” (p. 403). This point may sound a bit misleading. It seems to state that a basic package of health care must be provided for the indigent before ampler or better tiers of health care may be purchased by the affluent. However, following Engelhardt’s argument, he is actually saying that it is dependent upon individuals and communities themselves to decide whether they choose to provide a basic package of health care to everyone in society, and as to what will constitute a basic package of health care. Crucially, under the principle of permission, the state has no moral authority to prohibit the affluent from using their own resources to obtain better basic or luxury medical care, neither does it have moral authority to enforce a moral obligation on the affluent to establish a level of free health care for the indigent. Such an obligation can only be established through individuals’ voluntary choice, either directly or indirectly in a community not equivalent to a general society.

Fifth, “[a]n all-encompassing, single-payer plan, as has existed in Canada, is morally impermissible because it violates fundamental principle of secular morality. It is in this sense immoral” (p. 403). A basic national health care insurance for everyone in the society through commonly owned goods is certainly morally appropriate. However, if such a plan is an all-encompassing system in which individuals are not allowed to purchase better medical care or health service directly through insurance, it becomes immoral, because government has no moral authority to set this constraint on individuals.

Sixth, “[i]nequalities in health care are morally inescapable because individuals are free and differ in the scope of their needs and resources” (p. 403). Insofar as individuals are free to use their own property with consenting others to pursue certain goals as they see fit (this should be the case under the principle of permission),
inequalities in health care, just like inequalities in other fields, are inescapable. Here Engelhardt notes two major factors that generate inequalities in health care. First, individuals differ in the scope of their needs. A newborn having a congenital heart disease needs much more health care than a healthy infant. Some individuals suffer from various diseases for a great amount of time, while others are comparatively healthy for their entire period of life. Second, individuals differ in the scope of their resources. Those who have more resources can do things that those who have less resources are unable to do. Such inequalities are morally inevitable.

Finally, “[w]hether or not they are geographically located, given the limited secular moral authority of large-scale governments spanning pluralist societies, communities (e.g., the Roman Catholics) may develop their autonomous health care systems so that they need not be involved in morally objectionable health care services (e.g., be involved in abortion and euthanasia) and so that such services may be forbidden in their own facilities” (p. 403). Engelhardt notices that there are both geographically and nongeographically located associations or communities existing in the contemporary world. These communities should be able to create their own social systems, including healthcare systems. From his view, this conveys a number of advantages. First, the members of the community can clearly and fully give authority for the ways in which their resources are deployed. Second, they can avoid involvement in endeavors they find morally inappropriate (such as abortion and euthanasia to the Roman Catholics) and which members of the large society may wish to undertake. Finally, they can have the opportunity of creating a kind of personal law, a law that they may carry with them across geographical boundaries (pp. 161-162).
Evidently, Engelhardt’s view of health care distribution differs from any of the substantive accounts of health care justice that we addressed in the previous two chapters. As he sees it, a single-tier and all-encompassing healthcare delivery such as that which Singer supports is immoral, because it violates the principle of permission. Individuals have general secular moral authority to use their private resources to pursue a better healthcare as they deem appropriate. Moreover, Engelhardt’s account does not include anything like a principal positive right (to fair share of society’s scarce resources) that Fried proposes. Further, Engelhardt takes a health care free market (in which health services are sold and purchased as commodities) as morally inevitable in a pluralist society. This is not because the free market mechanism of allocation is more efficient than other patterns as Friedman argues. It is because government in a secular pluralist society has no moral authority to prohibit people from spending their own resources for what they value and peaceably pursue. Finally, Engelhardt admits that a basic package of health care may be created for everyone out of communal funds. But the legitimacy of such a creation depends upon the free choices of individuals regarding how to use communal goods, not upon any particular understanding of social justice, such as the principle of equality of net welfare (Veatch), the principle of equality of fair opportunities (Daniels), or the right to a decent minimum of health care (Beauchamp and Childress).

Engelhardt at times argues that “a two-tier system of health care delivery is morally unavoidable” (1992; 1993). This gives an impression that he supports the provision of a basic package of health care to everyone through the coercive act of the state. This is not the case. In fact, Engelhardt contends that “the contours of such a package should be recognized as a democratic creation, not a philosophical moral
discovery” (1993, p. 12). He insists that positive rights to health care are created, rather than discovered (1996, p. 403). A congenial example of an attempt democratically to create an adequate health care package is the Oregon Plan framed by the Oregon legislature in 1989 to provide basic health care to all Oregonians (1992; 1993). The Health Services Commission of Oregon used the results of an opinion poll, 47 town meetings, as well as commission hearings along with technical data in order to prioritize treatments. The goal was to use Medicaid funds to pay for as many items on a basic list of treatments, while covering 100 percent of Oregonians under the poverty line regardless of age or family structure.  

Engelhardt emphasizes the democratic feature of the Oregon approach as a great merit. He made a remarkable footnote in 1992:

Some people have considered the Oregon approach to be dangerous, in that it encourages citizens to consider how much they wish to tax themselves to provide a basic package of health care as well as to consider which health care services they would want to purchase. Such criticisms make sense if one presumes there are people in a secular society who are moral experts and can declare what God or reason requires to be expended for health care. Absent such assumptions, one may believe it is best to have members of Congress, rather than citizens in the several sovereign states or members of state legislatures, face these important decisions. There are no good data to show, however, that members of Congress

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36 Unfortunately, the Bush administration refused to provide the needed Medicaid waiver on the ground that the plan was discriminatory under the Americans with Disabilities Act of 1990 because it neither covered liver transplants for non-abstinent alcoholics nor provided neonatal intensive care for newborns with birth weights under 500 grams (see Engelhardt, 1993, p. 13).
are less venal or wiser in this matter than either members of state legislatures or the citizens of Oregon. Considering the timidity of members of Congress in facing the obvious - namely, that there must be a limit on how much money will be communally set aside to save the lives of Americans - one might in general think much more highly of the legislators and citizens of Oregon. In any event, in a matter as complex as this, it would seem ideal to have fifty concurrent discussions and experiments regarding the project of creating a basic adequate level of health care for all (1992, pp. 206-207).

Although there cannot be a justified view of justice to legitimize imposing a basic health care in society, Engelhardt argues that there are grounds for individuals and communities to agree to create a basic healthcare package. As he sees it, “[t]he creation of a basic adequate package through communal funds can be regarded as a prudent act of self-insurance, as a limited act of solidarity with others, or as a limited act of altruism” (1992, p. 196). He suspects that these and probably other reasons and goals will motivate citizens to create a basic package. Importantly, for Engelhardt, the moral authority of such a creation must be derived from a communal agreement (p. 196).

III. Justification

Engelhardt offers detailed arguments regarding how he has arrived at his principle of permission. In the following I lay out his arguments in four divisions.

1. The postmodern predicament as a sociological condition
The very first sentence of Engelhardt’s *Foundations* is: “Moral diversity is real” (1996, p. 3). His book begins with a recognition that there are distinct and concrete communities within which men and women live particular moral lives.

There are devout Jews, Protestants, Orthodox Catholics, Roman Catholics, Moslems, Hindus, and others. There are fervent egalitarians and libertarians. There are capitalists and socialists of various persuasions. There still remain even Marxists. Each possesses a concrete bioethics, however informally articulated (1996, p. viii).

For Engelhardt, there are as many ethics, bioethics and views of health care justice as there are major religions, ideologies, and world views. They each hold a content-full account of morality providing substantive guidance regarding what is right or wrong, good or bad, and praiseworthy or blameworthy. For instance, regarding health care,

> [e]ach account asserts its own priority. Some hold that euthanasia and physician-assisted suicide are morally appropriate to health care; others hold these practices to be immoral. Some consider commercial surrogate motherhood immoral; others consider that it is a way of acknowledging the dignity of women as free moral agents. Some argue that the rich should not be allowed to buy life-saving treatment unavailable to the poor; others argue that all should be free to purchase whatever treatment they are able. When asked how to justify these diverse moral understandings, some appeal to considerations of consequences; others appeal to principles of right or wrong that are independent of outcomes (1996, p. vii).

Contemporary societies are full of this cacophonous plurality of ethics, bioethics, and theories of health care justice. Moral disagreements occur not only regarding particular
issues such as physician assisted suicide and surrogate motherhood. People also disagree about how to justify a moral position. Consequently, individuals unavoidably encounter moral strangers, not only moral friends. They live with moral friends within their own moral communities, but they engage in moral strangers in general society.

Accordingly, for Engelhardt, a conceptual distinction between community and society is in order. Unlike many who see society as a community, Engelhardt argues that society is not a community. Instead, society comprises a great number of different moral communities. A moral community consists of moral friends, while society consists of moral strangers spanning different moral communities. In his account,

community is used to identity a body of men and women bound together by common moral traditions and/or practices around a shared vision of the good life, which allows them to collaborate as moral friends. Society is used to identify

37 The terms of moral strangers and moral friends are coined up by Engelhardt to characterize two basic types of human relation in contemporary large-scale pluralist societies:

Moral strangers are persons who do not share sufficient moral premises or rules of evidence and inference to resolve moral controversies by sound rational argument, or who do not have a common commitment to individuals or institutions in authority to resolve moral controversies. ...Moral friends are those who share enough of a content-full morality so that they can resolve moral controversies by sound moral argument or by an appeal to a jointly recognized moral authority whose jurisdiction they acknowledge as derived from a source other than common agreement (1996, p. 7).

This is not to say that, for Engelhardt, moral strangers must be alien to each other. Rather, “given the complexity of human circumstances and inclinations, moral strangers can be the best of affective friends” (p. 7). They even marry each other and form families. They are certainly not incomprehensible to each other. However, Engelhardt contends, although moral strangers recognize each other’s moral commitments, they understand them to be misguided and disordered.
an association that compasses individuals who find them in diverse moral communities” (1996, p. 7, italics original).

Engelhardt notices that many deny the existence of a real diversity among moral perspectives. He calls these people cosmopolitans. Cosmopolitans believe that individuals share enough in common so that a canonical content-full morality can be discovered to justify a particular bioethics and to establish an authoritative pattern of health care allocation. Why are these people blind to the moral plurality of contemporary society? Engelhardt’s diagnosis is that many of them “have goals that are primarily instrumental and immanent” (1996, p. ix). They often presume that differences in belief mask a more fundamental communality of immanent concerns. “The ever-present pleasures and opportunities of this life are seen to have first claim and ground final judgments” (1996, p. 9). Accordingly, they intend to seek a foundation for morality in that which is material and common. Moreover, for such cosmopolitans,

intractable moral disagreements may appear to be the result of fanaticism or ignorance. In addition, cosmopolitans often live their lives far from the substantive moral convictions that guide committed Orthodox Jews, Orthodox Catholics, Roman Catholics, Protestants, Moslems, and others who understand themselves within enduring and concrete moral traditions. It is difficult for cosmopolitan ecumenists to understand life within the embrace of traditional communities framed by transcendent commitments or to fathom the gulfs that separate different communities of the ideologically committed (1996, p. ix).

For Engelhardt, this blindness to moral diversity is also related to the modern philosophical or Enlightenment project. Unlike the character of the Western Middle
Ages in which people attempted to secure the moral substance and authority through a synergy of grace and reason, the modern Enlightenment project has attempted to reach a universal morality through rational argument and analysis alone (1996, p. 5). It inclines to ignore or discount the sociological fact of moral diversity in society because it promises to establish a generally-applicable, content-full moral account for persons as such, independent of any particular context of religion, tradition, or ideology that individuals actually hold. Indeed, if one could successfully demonstrate what is rationally revealed of moral content, one could (1) dismiss protests to the contrary as irrational, and (2) render the morality imposed by political power implicitly congenial, not alien to, the true nature of those individuals who are forced to conform (Engelhardt, 1991, p. xv). Thus, moral pluralism could certainly be overlooked. For Engelhardt, however, the Enlightenment project marks a failure to which we now turn.

2. The postmodern predicament as a philosophical failure

Engelhardt argues that the postmodern predicament is not simply grounded in the sociological condition of moral diversity. More importantly, the postmodern predicament represents a situation marked by a philosophical failure: the Enlightenment project that expects to use philosophical arguments to justify a content-full secular ethics has failed. Thus, for Engelhardt, the postmodern predicament indicates the epistemic crisis of morality.

In order through reason to discover a canonical morality among or independent of competing moral systems existing in society, the need is for a standard. A number of modern theoretical approaches and accounts have been designed to seek such standards.
Engelhardt briefly reviews intuitionist accounts, casuistic accounts, consequentialist accounts, hypothetical-choice theoretic accounts (including hypothetical contractor theories), rational choice accounts, game theoretical accounts (including prisoner dilemma-based accounts), natural law accounts, and middle-level principle-based accounts. He claims to demonstrate that they all suffer from quite common problems: “each presupposes exactly what it seeks to justify: a particular moral content” (1996, p. 43). In short,

each theoretical approach recapitulates the challenge of postmodernity: a moral theoretical account must either beg the question with regard to moral content (i.e., incorporate particular moral content without justification) or give no substantive guidance. Each attempt to a particular moral vision presupposes exactly what it seeks to establish so that moral theoretical arguments are at best expository, not justificatory. Even if one attempts a defense of secular ethics or bioethics on the basis of arguments that are not reducible to intuitionist, consequentialist, hypothetical-choice, or hypothetical-contractor arguments, or analysis of the nature of rational choices or game theoretic rationality or natural law arguments or middle-level principles analysis, the argument will fail as well (p. 43).

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38 Engelhardt suggests that these strategies can be classified into three categories: intuitionism, formalism, and naturalism. As he states, “[m]ore broadly, a standard can be sought in the content of moral thought (e.g., in intuitions), in the form of moral reasoning (e.g., in the idea of impartiality or rationality), or in some external objective reality (e.g., consequences of actions or the structure of reality)” (1996, p. 41). For Engelhardt, no such strategy can succeed. Briefly, “(1) appeal to any particular moral content begs the question of the standards by which the content is selected, (2) an appeal to a formal structure provides no moral content and therefore no content-full moral guidance, and (3) an appeal to an external reality will show what is, not what ought to be or how what is should be judged” (pp. 41-42).
Any substantive morality must begin with some substantive moral premises. Any substantive moral premise is inevitably controversial in contemporary pluralist society, because individuals hold different and incommensurable substantive moral premises. This predicament cannot be bypassed by any moral strategy. This is why Engelhardt argues that all philosophical strategies attempting to justify a standard morally have failed.

All concrete moral choices presuppose particular moral guidance. Moral content is achieved at the price of particularity. To have moral content, one must endorse particular moral premises or rules of moral evidence as a point of departure, thus endorsing one from among the class of available moralities. On the other hand, universality is approached at the price of content. For a morality to have content, it must be particular. But which particularity, which moral content, should be endorsed and on what basis? Again, to answer such questions, one either begs the question or submits to an infinite regress. In the face of these difficulties, no particular moral vision or bioethics, in general secular terms, can be shown to be better than any other (1996, pp. 58-59).

For Engelhardt, such incapacilities mark the contemporary philosophical and healthcare landscape. We can no longer hope to justify any particular substantive ethics or bioethics. Instead, Engelhardt contends that we must turn to a procedural morality.

3. From principles concerning moral content to a principle concerning moral authority

Given that philosophy is unable through sound rational argument to establish a substantive theory of justice or bioethics, we are left standing on the brink of nihilism.
As Engelhardt observes, "If one cannot discover an objective method to decide when the morally deviant are also the morally wrong, then the action of the morally heinous and the saint will be equally justifiable or lacking in justification" (1996, p. 66). All appears to become a matter of taste.

However, Engelhardt does not stop at the brink of nihilism. He argues that philosophy is still able to justify a way of resolving moral controversies with moral authority, although it is unable to justify one canonical particular morality. This is to say, for Engelhardt, when different moral positions are in conflict with one another, philosophy cannot tell us which position regarding moral content is right, but it can tell us which method in resolving moral controversies is right. Given the failure of the modern philosophical project in justifying a substantive moral discourse, Engelhardt directs the emphasis of ethical exploration away from the attempt to discover an objective ethical theory in the midst of moral diversity to the establishment of moral authority in resolving moral controversies among moral strangers. Thus, the focus of his moral philosophy moves to a principle concerning moral authority from principles concerning moral content.

According to Engelhardt, moral controversies can be resolved on the basis of (1) conversion of one party to the other's viewpoint, (2) justification of the objectivity of one particular viewpoint, (3) force, and (4) permission\(^{39}\) (1996, p. 67). Here by "moral controversies" Engelhardt means controversies among moral strangers in general secular moral society – those who do not share sufficient moral premises or rules of evidence and

\(^{39}\) Here I shifted his terminology a little bit to re-articulate his argument in the context of this essay.
inferences to resolve moral controversies by sound rational argument, or who do not recognize a common authority to resolve controversies. The postmodern predicament as a sociological fact indicates that the hope of conversion of all people to one position has failed. The postmodern predicament as a philosophical failure shows that the strategies of justification do not work to resolve such controversies. Hence we have to resolve moral controversies either by force or by permission. Which way carries moral authority?

Engelhardt provides a transcendental argument for a way of resolving moral controversies among moral strangers on the basis of permission. He proceeds from a necessary sense of the notion of ethics (1996, pp. 70-71). His argument can be summarized as follows:

(a) A necessary sense of ethics is that one may never use force to resolve moral controversies unless it is justified;

(b) Force using may be justified in the case that at least one viewpoint is discovered as universally right or wrong; when a moral viewpoint is disclosed as correct, it may be right to use force to carry it out; when a viewpoint is discovered as morally wrong, it may be right to use force to prohibit it. At least in some of such cases, using force may be justified, even if it cannot be justified in all the cases.

(c) Force using in the first place to resolve moral controversies among moral strangers can never be justified, because no moral viewpoint held by moral

\[40\] Certainly, even for moral friends within a common community, there can also be moral controversies. However, Engelhardt would contend that they are a type of controversies differing from controversies among moral strangers. Moral controversies among moral friends can be resolved by sound rational argument on the bases of sufficiently shared moral premises and rules of evidence and inference, by listening to God similarly, or by common commitment to an authority. In contrast, moral controversies among moral strangers cannot be resolved through these means.

\[41\] When a moral viewpoint is disclosed as correct, it may be right to use force to carry it out; when a viewpoint is discovered as morally wrong, it may be right to use force to prohibit it. At least in some of such cases, using force may be justified, even if it cannot be justified in all the cases.
strangers can be established as universally right or wrong without begging the question;\textsuperscript{42}

(d) Therefore, a necessary sense of ethics is that force may never be used in the first place to resolve moral controversies among moral strangers.

This is to say, an attempt to using force in the first place to resolve moral controversies among moral strangers can never have moral authority. Now, when moral controversies among moral strangers may not be resolved by force, or by an appeal to a generally justifiable view of moral rationalities, Engelhardt concludes that, by default, moral controversies among moral strangers can only be resolved by permission. "Authority for actions involving others in a secular pluralist society is derived from their permission" (1996, p. 122). Thus the principle of permission as a principle concerning moral authority among moral strangers is established.

It is important to recognize that what Engelhardt offers is a transcendental argument.\textsuperscript{43} It does not start with an assumption regarding any vital or universal value.

\textsuperscript{42} Here the condition of "in the first place" is necessary. Force using may be justified among moral strangers if one uses it in self-defense. In such a situation one cannot be the first who uses or threats to use force.

\textsuperscript{43} A transcendental argument sets down necessary conditions that make a major domain of human experience possible. Such a transcendental argument in the case of Engelhardt's moral argument is principally Kantian. However, although Kant underscores morality's presupposition of freedom, he restricts transcendental claims to areas of theoretical knowledge and does not extend them to claims about morality. Engelhardt extends transcendental arguments to moral areas. For Engelhardt, given that "transcendental" is used to identify an argument that lays out the conditions for the possibility of a major domain of human experience, one can certainly extend it to the sphere of moral experience. What is crucial here is that, as defining conditions, transcendental conditions must be \textit{a priori}. They sketch general conceptual frameworks within which science and morality become possible. For Kant's explication of transcendental arguments, see Kant, 1965, A11=B25, p. 59. For an illuminating discussion of transcendental arguments, see Engelhardt (1996, notes 82-83, pp. 94-96).
In particular, it does not proceed from the assumption that force is bad, whereas peaceableness is good, therefore force may not be allowed. Instead, it begins with a minimal necessary sense of ethics, i.e., force may not be used without justification.\textsuperscript{44}

This view of ethics and bioethics is not grounded in a concern for peaceableness. It is not based on an interest in establishing a peaceable community. This view cannot be shown in general secular terms to be good, praiseworthy, or rationally to be desired. It should, instead, be recognized as a disclosure, to borrow a Kantian notion, of a transcendental condition, a necessary condition for the possibility of a general domain of human life and of the life of persons generally. It is a disclosure of the minimum grammar involved in speaking of blame and praise with moral strangers, and for establishing a particular set of moral commitments with an authority other than through force. This account can be regarded as a transcendental argument to justify a principle of freedom as a side constraint, as a source of authority. The authority of freedom as a side constraint, the principle that one may not use others without permission, derives from this being a necessary condition for the possibility of a major endeavor of persons: a secular moral fabric that can be justified to, and that can bind, moral strangers. Just as certain conditions must be presupposed for the very possibility of scientific

\textsuperscript{44} It might be misleading to call Engelhardt’s principle of permission “content-less.” Given that it holds a particular requirement (namely, force may not be used in the first place to resolve moral controversies among moral strangers), it certainly has content - its primary content is this requirement. However, it’s distinctive character lies in that it does not impose any substantive moral viewpoint upon others who do not so accept. Only in this sense it is content-less. It does not entail any particular ranking of values. It might more accurate to characterize it as a procedural principle, in contrast with other moral principles that carry substantive moral requirements.
reasoning, so here one finds a basic, minimum presupposition of secular ethics (1996, p. 70).

Indeed, compared to traditional moral principles concerned about substantive moral guidance (where procedural moral principles are only secondary in moral significance), Engelhardt's principle of permission is procedural. He believes that this is the most that we can secure through philosophical argument.

4. The role of the state

If general pluralist society must be regulated by the principle of permission, then what moral authority does the state have? In particular, what can the state do regarding healthcare allocation with moral authority? Engelhardt explores several traditional ways in which authority for the state has been justified: the authority of the state from God, from a morally canonical concrete understanding of the good life, from an appeal to a hypothetical contract, from the notion of an actual past agreement, and from consideration of prudence. Engelhardt argues that the postmodern philosophical predicament demonstrates that all these types of justification have failed and must fail (1996, pp. 166-171). "One is then brought to the final source for the moral authority of government, namely, the actual consent of the citizens to the actions of the government" (1996, p. 171).

Engelhardt also provides a peculiar Hegelian interpretation of the state. As he sees it, whatever Hegel's own expectation may be, the Hegelian categorial explanation displayed in Philosophy of Right demonstrates that "[t]he state affords a political unity and an identity, not a social unity and identity" (1994, p. 218). In a contemporary large-
scale state, a variety of moral communities hold different and incompatible moral perspectives and narratives. This “pluralism of moral narratives cannot be overcome in a higher level content-full moral narrative.” Instead, “it can be overcome in a mode of social organization that does not require further moral content.” The state should be such an organization that “does not require further moral content.” The state should no longer be a particular moral community. Instead, it combines diverse moral communities through a political structure, “a neutral limited democracy.” Accordingly, a state that “does not unite its diverse communities ceases to be a state.” “A state that suppresses the content-full, peaceable diversity of its communities evacuates its specific content” (1994, p. 222). The category of state succeeds precisely by generating a social unity that is not communal. In summary, diverse moral communities form a state, a political unity, that should not set aside the context of diversity of communities it spans. Here the categorial significance of the state is not derived from permission or contract but constitutes a moral space for contractual collaboration.

In this way Engelhardt can suggest a possible harmony between Hegel’s categorial account and Engelhardt’s defenses of a limited democracy. In any event, Engelhardt derives a principle of political authority from his principle of permission:

Morally justified political authority is derived from the consent of the governed, not from a canonical content-full understanding of the good life or moral obligations, including commitments to beneficence; the actual significance of such views or commitments must be framed by common agreement (1996, p. 177).

In addition, Engelhardt emphasizes the categorial character of the state. “The state is
precisely that social structure in which one can understand a moral authority binding
persons and communities with different moral visions and through which general rights
to forbearance can be secured and protected” (p. 177). Where moralities are diverse, the
state must leave moral spaces to individuals and their communities. “Such spaces can be
understood as marked or bordered by rights to privacy” (p. 177).

Specifically, Engelhardt contends that political or corporate entities possess
authority to:

i. Protect the innocent from unconsented-to force (e.g., against being subjects of
medical experimentation without their consent, or from having their free access to
private health care impeded);

ii. Enforce contracts (e.g., the commitment to confidentiality on the part of
physician);

iii. Develop welfare rights through the use of common resources (e.g., health care
welfare rights);

iv. Clarify boundaries and establish procedures to resolve disputes when such
cannot be accomplished through market mechanisms and then only while

The whole range of activities is embedded in permission as the source of secular moral
authority.

IV. Critique
Engelhardt’s description of the postmodern predicament as a sociological condition is accurate. His disclosure of the postmodern predicament as a philosophical failure is well done. His transcendental argument for a general secular ethics (and bioethics), i.e., for a way of resolving moral controversies in general society other than through force, is also defensible. Although a number of scholars have raised a variety of criticisms regarding these aspects of Engelhardt’s account (e.g., Minogue, et al., 1997), these criticisms do not pose a theoretical challenge that Engelardt’s account is not able to put aside.⁴⁵

The major difficulty of Engelhardt’s theory, as I see it, lies in its application. I must quickly add that here I am not talking about the theory-reality-gap cliché that many often like to mention (“the theory is one thing, but the reality is another”). I don’t think that is a problem from which Engelhardt’s account suffers. What Engelhardt’s theory lacks for its application is a necessary further interpretation of his account. This interpretation is necessary because without it Engelhardt’s theory cannot be applied. Significantly, this necessary further interpretation of Engelhardt’s secular ethics must provide an account of which actions involve others (as well as which actions do not involve others) so as to determine when one must obtain anothers’ permission (or when one may forgo anothers’ permission) in order to undertake action. Only with such an account in hands, can Engelhardt’s principle of permission be applied.

As we have shown, Engelhardt’s secular ethics is dedicated to resolve moral controversies among moral strangers with moral authority. It discloses the minimum sense of ethics of not using unjustified force to resolve controversies. As we have discussed, the core of this ethics, the principle of permission, states that “[a]uthority for

⁴⁵ Engelhardt offers detailed answers to the critiques of his theory in his 1997.
actions involving others in a secular pluralist society is derived from their permission” (1996, p. 122). This is to say, for actions that do not involve others, the actor has moral authority to do what he deems morally appropriate without the need of obtaining permission from others, while for actions that involve others, the actor must obtain permission from others in order to do them with moral authority. Now, suppose people have accepted Engelhardt’s secular ethics and have begun to consider applying his principle of permission to regulate actual ethical and bioethical issues, they would immediately find themselves encountering controversies that cannot be resolved by appeal to the principle of permission: namely, what actions involve others, and what actions do not involve others? In other words, this type of controversies does not fall in the scope of controversies that should be governed by the principle of permission under Engelhardt’s general secular ethics. To the contrary, the resolution of such controversies constitutes the very precondition of applying the permission principle to resolve other types of controversies. Indeed, this precondition indicates the limit of the principle of permission.  

46 Disagreements presuppose agreements, just as contingency presupposes necessity. There cannot be controversies without agreements. In order to disagree, individuals have to agree about how to disagree. Disputes about the permission principle cannot be resolved by appeal to the principle itself. In fact, Engelhardt is aware of the problem. As he concedes, “there will be issues to be settled that cannot be resolved by the agreement of all. Property boundary lines must be established, punishments for crimes determined, the jurisdiction of courts specified, and a series of determinations in gray areas set by situation” (1996, p. 171). But he does not address full range of the issue.

47 It is heuristic to make a comparison between Engelhardt’s principle of permission and J. S. Mill’s principle of no harm (which he calls “one very simple principle”). Mill
There certainly are clear-cut cases in any society as to whether one’s actions involve or do not involve others. But there are also many cases where disputes exist. Some might contend that all humans are related to each other in one way or another, so any action is inevitably involved with others in some sense. Even if we consider this position as an extreme and do not take it seriously, there remain a great number of borderline cases in which one’s actions involve others. Indeed, human society would not have existed if humans had not undertaken any actions without obtaining others’ consent in the early times of human history. Accordingly, in order to provide an account of involvement for applying Engelhardt’s principle of permission, a normative sense of involvement is unavoidable. Namely, we must make a fundamental assumption regarding the normality of involvement: one’s action may legitimately or illegitimately involve others. If one’s action only legitimately involves others, one does not need to

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claims that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others” (Mill, 1986, p. 16). Evidently, Mill’s emphasis is placed on “no harm” - the state has authority to intervene in protecting individuals from harm inflicted by others. In contrast, Engelhardt’s focus is on “permission” - the state has authority to intervene in protecting individuals from unconsented-to force imposed by others. Both Mill and Engelhardt agree that one’s own good, either physical or moral, is not a sufficient warrant for state intervention. However, their principles differ in at least two important aspects. First, Engelhardt’s principle is anti-paternalistic. Insofar as one’s action involves others, one must obtain others’ permission, even if one intends to do the good to others. In contrast, it is not clear that Mill’s principle has such a requirement. Moreover, Engelhardt’s principle is pro-voluntaristic. Competent individuals have liberty to make contracts with others to do things that may generally be considered a harm to themselves. For instance, one has liberty to join the French Foreign Legion, one can consent to enslave oneself, and so on. Again, it is unclear whether Mill’s principle would allow such actions.

48 The initial appropriation of land is a good and important example. Owning a piece of land is certainly an action involving others, but one does not have to obtain others’ permission if it is a legitimate involvement.
obtain others’ permission to undertake the action. On the other hand, if it is unclear whether the involvement is legitimate, one must obtain others’ permission to perform the action. Accordingly, we need to afford an explanation about how one’s actions involve others. For the sake of simplicity, let me call this explanation an account of involvement, call actions that legitimately involve others or do not involve others no-others-involving actions, and call actions whose involvement with others may not be legitimate others-involving actions. In the following I address this issue under four types of disputes.49

The first type of disputes touches the nature of action. One’s action may involve others mentally, physically, and/or economically. There are often controversies over whether an action’s involvement with others is legitimate. For instance, some argue that kissing behaviors in public should be prohibited, because such behaviors make them feel uncomfortable. But others believe that such behaviors are simply no-others-involving actions, or if they have some mental influence on others, that is a legitimate influence. For another example, should a general bookstore be allowed to sell pornography? Some people argue that they should be, since those who do not like pornography do not have to look at it. But other people argue that even a glimpse of the cover of these things makes them feel disgusting, while in a book store where pornography is allayed they have no way to avoid such a glimpse. Hence, for them, selling pornography in a general

49 Joel Feinberg’s discussion of the different senses of “harm” is suggestive to our consideration of Engelhard’s senses of “involvement.” Feinberg distinguishes three senses of “harm” existing in general circulation. The first is a derivative or extended sense in which any kind of thing can be harmed. The second is a basic sense in which harm is conceived as the thwarting, setting back, or defeating of an interest. The third is a kind of normative sense in which to say that A has harmed B is to say much the same thing as that A has wronged B, or treated him unjustly. He argues that employing the harm principle in society requires a strict sense of harm in which A harms B when (1) A sets back B’s interests, and (2) A does this in such a manner as to violate B’s right (i.e., wrong him) (1984, pp. 31-36).
bookstore must be an others-involving action, and it should not be allowed to sell in such stores, even if it may be allowed to sell in special stores. Finally, a state-owned-company businessman living in a stage of economic transition might argue that the government’s new policy of changing the centrally planning economy to a free market economy unfairly disadvantages his company. Because his business used to be required by the government to follow the state plan rather than market changes, his business does not have the capacity to compete with the type of market-oriented enterprises that are arising through the government’s new policy. Therefore this competition is unfair. If anyone wants to set up a business similar to his, he would insist, it will be an others-involving action (i.e., involving him and his employees). Accordingly, such an action must get his permission in the first place.  

The second type of disputes involves the degree of action. For instance, when one sings a song in one’s own room, this is generally a no-others-involving action. However, if one sings very loudly and persists for a long time, that would make it become an others-involving action (i.e., involving his neighbors). But the issue of how loudly and for how long one’s singing should be so as to make it qualified as an others-involving action cannot always be settled by implicit or explicit agreements. It needs to be resolved by an authority.

50 Cases of this type are available in current China’s reform to the free market economy from centrally planned economy.

51 I still vividly recall a terrible dispute happening in Beijing six years ago between my next-door neighbor and his upstairs neighbor who walked too heavily (according to my next-door neighbor’s opinion) on the floor. They never reached an agreement about the matter.
The third type of disputes involves the change of implicit agreement. There are a great amount of implicit (or tacit) agreements in social practice that give allowance to a series of others-involving actions. However, as situation changes, some people may change their mind and want to withdraw some of their agreements that they already implicitly or tacitly given. A good example in this respect is population policy. In contemporary society, many believe that reproduction is no longer a no-others-involving action. Because everyone consumes commonly shared resources in society, those families that recreate more children than others consume more commonly shared resources than others; and this is unfair. This consideration constitutes a basis for many to argue for a population control policy. More and more people do not want to allow others’ reproductive actions without any limitations. However, on the other hand, some insist that reproduction is a natural right and that the issue of how many children a family wishes to have is a no-others-involving action.

Finally, there is a type of non-action that may also involve others. Suppose one does not want to mow the grass of one’s yard. One may argue that this has nothing to do with others. In any case, it is one’s own yard, grass, and non-action. However, his neighbors may argue that, because the messy grass of his yard destroys the entire environment and lowers the price of the estate in the community, his non-action is actually an others-involving action. Similarly, if one refuses to accept treatment of one’s infectious disease, others can argue that his non-action is an others-involving action, because he puts others under the risk of contracting the disease.

These examples demonstrate that an account of involvement can be very complicated. In one sense, as we mentioned, any action in the world can have some kind
of influence upon others. Some might want to argue that as long as an action has some influence on others, that action is involved with others. Accordingly, they might want to claim that, according to Engelhardt's general ethics, every action should obtain others' permission. This, they might conclude, makes Engelhardt's theory nonsensical. However, this is an extreme position that cannot be correct. We would argue that it is most important to distinguish legitimate from illegitimate involvement. Not all types of influences are illegitimate involvement. Engelhardt's principle of permission only requires obtaining permission for those actions whose involvement in others may not be legitimate. On the other hand, some might want to argue that as long as one is voluntarily performing an action through one's own resources, that action does not involve others, so that performing any of such actions does not need to obtain others' permission. This is a position held at an opposite extreme that cannot be right, either. Moreover, disputes regarding involvement cannot be resolved by the agreement of all. Authority in secular society must establish standards for them.

Finally, as for any other issues, different communities may understand involvement differently. For instance, in community A organ donation is understood as an action that does not involve one's parents. Hence, one does not need to obtain the permission of one's parents to donate an organ. In contrast, in community B organ donation may be understood as an action that involves one's parents, because one's body is given by the parents. Secular authority must take into account such differences between communities in order to set up appropriate standards for involvement.

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52 The Confucian community may hold the latter position. As Confucians understand it, one's body is given by one's parents. So one does not entirely own one's body. Instead, one's body belongs to one's parents in a significant sense.
Chapter Five

ACCOUNTS, THEORIES, AND PERSPECTIVES

I. Accounts, Theories, and Perspectives: An Introduction

Chapters Two, Three, and Four examined seven different moral theories and their respective accounts of health care justice. These theories and accounts fall into two primary forms: substantive and procedural. These chapters demonstrated that the substantive theories and accounts failed to offer convincing argument for the full strength of their moral claims. However, substantive accounts of just health care remain the dominant accounts in the literature, dominant in the sense that most articles addressing the subject belong to this type. How can this be the case? This chapter argues that its dominance can be explained in terms of the intellectual focus on normative moral theories, rather than on what I term particular moral perspectives, namely, broad and detailed pictures of real moral exploration and deliberation.

Focus on normative moral theories leads to ways in which the diversity and plurality of real moral commitments and convictions are overlooked. Although a normative moral theory which identifies some general moral principles or doctrines (such as Daniels’ principle of fair equality of opportunity or Fried’s doctrine of a right to a fair share of the community’s scarce resources) is substantive in moral content, it is still very general and abstract. Such a theory can easily obtain the support of the intuitions of some individuals, ignoring the fact that there are a great number of such principles and doctrines which are often in conflict with each other and supported by contrary intuitions.
Indeed, who would object to such general slogans as "liberty," "equality," "justice," "rights," and so on? Consequently, by focusing on such formal generalizations, a false consciousness of moral consensus can be created. It seems that all can agree on some general substantive principles or doctrines. In this strategy the nuance of real moral exploration is easily ignored.

Moreover, focusing on normative moral theories also generates the impression that concrete moral conclusions are directly derived from normative moral theories and thereby justified. Indeed, even the structure of the presentation in the previous chapters may suggest that those accounts of health care justice are directly derived from different moral theories, such as Veatch’s egalitarian theory, Daniels’ contractarian theory, Singer’s utilitarian theory, Friedman’s economic theory, Fried’s deontological theory, Beachampt and Childress’ mid-level theory, and Engelhardt’s postmodern theory. It may also generate the impression that different types of moral theories lead to different accounts of just health care, while similar moral theories give rise to similar patterns of health care allocation. It might be thought, for example, that all utilitarians support more or less similar modes of health care distribution, while all deontologists agree concerning their understandings of just health care. There might then be the conclusion that which view of social justice in health care one endorses depends on which normative moral theory one accepts.

Invoking a normative moral theory to justify an account of the proper allocation of health care presupposes that such an account could gain universal acceptability by itself as well as by the source of its specific conclusions regarding the appropriate delivery of health care. This chapter suggests that it is this assumption that accounts for
the popularity of substantive accounts of social justice in health care. However, a further exploration of the accounts we have examined indicates that this assumption is false.

First, there is no simple logical relationship between the normative moral theory that one adopts and the substantive conclusions that one draws regarding social justice in health care. Further comparing the theories we discussed in the previous chapters shows that the same theory may generate different accounts, while different theories may lead to the same account. For example, although Friedman and Singer are both committed to the utilitarian theory, Friedman supports a free market distribution of health care, while Singer argues for an entirely state-controlled health care system. Although Veatch and Daniels both use contractarian theories to build their accounts, Daniels requires justice to be realized in society as the first priority, while Veatch holds that the requirement of justice is only one of a set of equally binding principles. Although both Fried and Engelhardt develop deontological accounts, Fried argues for a general positive right to scarce societal resources, while Engelhardt lays out a general secular morality in terms of individual permission and cooperation. Moreover, although Beauchamp is a utilitarian and Childress a deontologist, they have come to the same set of moral principles and together argue for a right to a decent minimum of health care.

At first blush this state of affairs is puzzling. How can the same normative moral theory lead to different accounts of health care justice (as in the cases of Veatch and Daniels, Friedman and Singer, and Fried and Engelhardt)? How can different normative moral theories generate the same account of health care justice (as in the case of Beauchamp and Childress)? In fact, these circumstances indicate that the general character of a normative moral theory does not exhaust all the moral content or substance
involved in the use of such theories. This suggests that we need to consider what a real relation is there between a normative moral theory that one adopts and the particular moral content or substance that one holds. By normative moral theories I have in mind such theories as utilitarianism, deontology, contractarianism, egalitarianism, and so on. By moral content or substance I mean the concrete moral commitments that guide actual individual conduct (e.g., how should a physician treat a patient?), institutional action (e.g., should a Roman Catholic hospital provide abortion services?), or governmental policy (e.g., should a government offer universal healthcare coverage through taxation?). Accordingly, moral accounts of social justice in health care provide moral substance beyond what is included in a normative moral theory because they give concrete guidance as to how health care should be distributed. The question is then where a normative moral theory stands. Why is it necessary to adopt a normative moral theory to offer an account of health care justice? Is it because we do not have moral standards in our moral lives, and we must use normative moral theories to obtain such standards?

We certainly have moral standards. Our inherited moral traditions, ideas, and rules as well as moral intuitions and judgments accompany our moral practices and offer us specific moral instructions. We do not have to hold a moral theory to obtain moral instructions because guidance is already available. However, since such non-theorized moral instructions are non-discursive, non-systematic, and even fragmented, individuals may want to reflect on them and inquire about whether they give right moral guidance, especially when individuals encounter difficult moral problems. They expect that a normative moral theory can provide the right moral standards. Obviously, if a normative
moral theory is justified, then it would offer the right moral guidance.\textsuperscript{53} Hence, individuals are interested in establishing and adopting a normative moral theory to attain a true substantive morality for moral practice. This is also the case for the theorists under discussion. Each appeals to a normative moral theory to derive a morally appropriate account of health care justice to regulate health care allocation.

Logically, when two (or more) different moral conclusions on the same subject are derived from the same normative moral theory, there are several possibilities in order. First, the theory may be incoherent in itself. Second, although the theory is coherent, some mistakes are made in drawing inferences from the theory. Third, although the same theory is adopted, different factual, metaphysical, or religious beliefs are appealed to in the process of drawing inference so that different conclusions are reached. Fourth, two or more different types of theories are hidden behind the apparently single theory. Finally, the theory is by itself insufficient to draw any specific conclusion regarding the subject unless further interpretations of the theory are introduced. Given the circumstances of the theories and theorists involved in this discussion, the first and second possibilities can be put aside. The third possibility may be involved in some aspects, but it is not sufficient to explain away all of the puzzles. The fourth possibility is an \textit{ad hoc} explanation. One can always identify different theories if one finds different conclusions arising from a theory. But this would lead to a very loose definition of normative moral theories and result in intolerably numerous theories. The only plausible explanation is the last possibility: a normative moral theory is by itself insufficient to draw any concrete conclusion unless

\textsuperscript{53} Thomas Nagel holds to the contrary though: "I believe one should trust problems over solutions, intuition over arguments, and pluralistic discord over systematic harmony" (1993, p. x).
further interpretations of the theory are introduced. Under this explanation, it is easy to understand that different conclusions can be derived from the same normative moral theory, because different further interpretations of the theory have been provided. Consequently, introducing different interpretations to a moral theory leads to different concrete moral conclusions from the same theory.54

Similarly, when two different types of theories lead to the same account of health care justice (as in the case of Beauchamp’s utilitarianism and Childress’ deontology), there can be several possibilities. First, some misunderstandings are involved concerning one or both of the theories. Second, although each of the two theories is sufficient to generate an account of health care justice, they happen to generate the same account. Finally, neither of the two theories is by itself sufficient to generate an account of health care justice without introducing further interpretation of the theory, and a similar further interpretation is offered to each of the two theories so that they lead to the same account of health care justice. The first possibility can be put aside at least in the case of Beauchamp and Childress. It is unlikely that they have misunderstood the utilitarian or deontological theory. The second possibility can be ruled out because other utilitarians (such as Friedman and Singer) and deontologists (such as Fried and Engelhardt) have worked out accounts of health care justice that differ from Beauchamp and Childress’ account. As I will show in the next section, I hold that the third possibility is the best explanation of the Beauchamp and Childress’ case. That is, they each offer a similar interpretation of their respectively different moral theories.

54 I use “interpretation” in a broad sense. It includes specification, ranking, and balancing.
This preliminary exploration of the two apparent puzzles discloses two important facts: (1) one is not able to use a normative moral theory to draw concrete moral conclusions without introducing a further interpretation of the theory, and (2) different interpretations lead to different conclusions. This suggests that our usual observation (that a normal moral theory directly leads to particular moral conclusions) is incorrect. There is not a direct relation of reciprocity between normative moral theories and substantive moral standards. There must be particular interpretations standing between the general theory and concrete contexts to which the theory is applied to bridge them in order for the theory to generate specific moral conclusions, because the theory is inevitably general.\textsuperscript{55} Hence, it is a normative moral theory together with some such interpretations that are able to provide concrete moral guidance. Without such interpretations, there is no specific moral guidance. Accordingly, what is crucial in obtaining particular moral standards is not a normative moral theory alone. It is rather a normative moral theory plus specific interpretations of it that serve to justify moral substance. Such interpretations are not contained in the original theory but is attached to the theory from the outside. Thus, it will be convenient to use a particular notion to express such a connection between a normative moral theory and its specific interpretations. Such a notion may clearly indicate how moral substance is actually obtained and/or justified in our moral deliberations.

I will use the notion of a \textit{moral perspective} to refer to the whole system of a normative moral theory \textit{and} additionally attached specific interpretations to the theory.

\textsuperscript{55} A theory that does not guide generally cannot be a theory by nature. If a theory is not general in itself, it cannot guide generally. Hence, a theory must be general.
Consequently, there exists a tripartite relation among moral content (or substance), a normative moral theory, and a moral perspective. Moral content consists of specific moral standards regarding individual conduct (and/or character), institutional action, and governmental policy. Such standards cannot be derived from a normative moral theory alone; instead, they can only be derived from a moral perspective, which is comprised of one or more normative moral theories and additional interpretations attached to them, while a normative moral theory, as part of a moral perspective, offers only abstract generalization, reflection, and argument within the structure of a moral perspective.\(^\text{56}\)

Following Thomas Kuhn’s use of “paradigm” to characterize normal scientific activities and communities (1970, especially “Postscript”), I employ “a moral perspective” to characterize our moral activities and reasoning. A moral perspective consists of three types of components.\(^\text{57}\)

The first type of components is formal generalizations. They can be seen as equivalent to a normative moral theory contained within a moral perspective. Examples of such formal generalizations include Kant’s categorical imperative and the utilitarian

\(^{56}\) In their (1994, pp. 44-45), Beauchamp and Childress observe that a normative moral theory commonly refers to “(1) abstract reflection and argument, (2) systematic reflection and argument, and (3) an integrated body of principles that are coherent and well-developed.” They mention that they do not claim that their principle-based theory has reached a level suggested by (3). This essay assumes that normative moral theories stay at an abstract or formal level. Whether they are formally systematic, they are not content-full. For example, Kant’s deontology, consisting of categorical imperatives, is well argued and systematic, but it is not content-full until Kant offers specific interpretations (by adding particular premises) and develops concrete moral standards. When it becomes content-full, it becomes a moral perspective, no longer an abstract moral theory.

\(^{57}\) Following Kuhn’s example of paradigms does not suggest that science and morality are similar disciplines or practices. My notion of “a moral perspective” is only a formal, not substantive, “borrowing” from Kuhn’s “paradigm.”
principle of utility. The former states that we ought always to treat persons as ends, not merely as means. The latter asserts that we ought always to produce the maximal balance of value over disvalue. These are formal statements because extra explanations are required regarding what “ends,” “means,” “value,” and “disvalue” are specifically meant in order to apply these statements, and such explanations are not included inside of them. It is further interpretations of these formal generalizations that provide such explanations. Hence, formal generalizations in moral perspective need further specifications in order to be applied.

The second type of the components of a moral perspective is metaethical beliefs regarding the nature of morality, the methods of moral justification, and appropriate moral epistemology. The nature of morality concerns whether morality is objective or subjective, rational or emotional, and relative or absolute. The methods of moral justification concern how to justify moral rules, ideas, judgments, theories, and so on. The often-mentioned methods include self-evident axioms, reflective equilibrium, transcendental approaches, and so on. Moral epistemology cares about what constitutes appropriate moral evidence as well as what are appropriate rules of inference.

The third type of the components of a moral perspective is exemplars. I identify this component as the central element of a moral perspective. An exemplar is defined in terms of three ingredients: (1) detailed interpretations (including specifying, ranking, balancing, etc.) of the formal generalizations of a moral perspective, (2) concrete problem-solutions and/or paradigm case-analyses, and (3) specific moral commitments. As an example of ingredient (1), David Ross explains his moral principles as prima facie binding rules that cannot be given a fixed ranking but must be balanced in the context
according to the agent’s judgment. Kant’s exploration of the issues of suicide, promise-keeping, talents-cultivation, and assisting others in need in his *Grounding for the Metaphysics of Morals* (1981, pp. 30-32) provides a salient example of concrete problem-solutions and paradigm case-analyses for the Kantian moral perspective. Finally, as an example of ingredient (3), such commitments as “abortion is morally evil,” “active euthanasia is morally wrong,” and so on are included in the Roman Catholic moral perspective.58

Indeed, exemplars are cardinally important to a moral perspective. Different moral perspectives may share the same formal generalizations (i.e., they may use the same normative moral theory) and even the same metaethical beliefs, but they remain different moral perspectives if they hold different exemplars. On the other hand, even if two moral approaches hold different formal generalizations and/or different metaethical beliefs, they may still be labeled the same moral perspective, if they share the same specific moral commitments and offer the same interpretations of their respective formal generalizations as well as appeal to the similar concrete problem-solutions and/or

58 Concrete problem-solutions and/or paradigm case-analyses are worth special attention. Applying moral principles and rules to our moral practice relies on our understanding of them. Our understanding involves more than verbal means. As Michael Polanyi observes, “all knowledge by which man surpasses the animals is acquired by the use of language,” but “the operations of language rely ultimately on our tacit intellectual powers” (1962, p. 95). In other words, our understanding of moral principles and rules is not derived from our ability to give them verbal statements (articulated knowledge). It is rather acquired through our tacit knowledge of how to use them (inarticulated knowledge). Since the verbal statements of principles and rules are virtually impotent, our tacit knowledge of them is not learned by reciting them. Instead, it is acquired by concrete examples of how they function in our moral practice. Such examples are provided in concrete problem-solutions and/or paradigm case-analyses within a moral perspective.
paradigm case-analyses. Of course, they may very probably contain different religious and/or metaphysical views. However, because these views do not make any real difference in their moral substance, they still hold the same moral perspective.

With the notion of a moral perspective available, we can now obtain a clearer picture of the accounts of health care justice as well as their respective underlying moral theories that we discussed in the previous chapters. When each of these theorists argues for his own moral theory, he is best considered to be displaying a particular moral perspective that he holds. Indeed, each of them (Veatch, Daniels, Singer, Friedman, Fried, Beauchamp and Childress, and Engelhardt) illustrates a particular moral perspective. Each account of just health care they affords constitutes a well-organized problem-solution from their respective moral perspectives. In addition, each of these moral perspectives includes one or more abstract normative moral theories. Specifically, Veatch’s moral perspective includes deontology, egalitarianism, and contractarianism. Daniels’ includes deontology and contractarianism. Singer’s includes utilitarianism and egalitarianism. Friedman’s includes utilitarianism and libertarianism. Fried’s includes deontology. And Engelhardt’s includes deontology and libertarianism.59

In summary, a moral perspective includes full content of a morality lived by a group of people. A moral theory identifies general moral statements formulatable within a moral perspective. And a moral account reconstructs in a systematic way a moral

59 From the strategy of moral perspectives, a great deal of methodological debates among different bioethical approaches (such as principlism, theory-based approach, casuistry, narrative-based approach, virtue theory, and so on) may not be important at all, especially when they do not hold different moral commitments and do not generate really different problem-solutions.
perspective regarding a particular domain of issues. A moral perspective is most inclusive and is not entirely discursive. It is the image of real moral life lived by people. On the other hand, a moral theory is both general and systematic. It is composed of formal generalizations proven vague, ambiguous, and least determined without further interpretation. Finally, a moral account is a well-organized moral approach including both general principles and specific conclusions. A moral account is not derived from any moral theory. It is rather a conceptual reconstruction of a moral perspective regarding a domain of moral issues. Hence, all the six substantive accounts of just health care we discussed in the foregoing chapters reconstruct the particular moral perspectives that the authors respectively hold concerning the issue of social justice in health care. Only full-bodied moral perspectives give full substance to those accounts.

The following four sections of this chapter include two forms. The first form shows how Beauchamp and Childress, although affirming different moral theories, in fact possess the same moral perspective. It explains why their moral perspective, although they claim it to be the one “embedded in the common morality,” is still one of the many different particular moral perspectives in moral reality. The second form highlights pairs of theorists to show how they in fact hold different moral perspectives although they appeal to the same normative moral theory: utilitarians Singer and Friedman, contractarians Veatch and Daniels, and deontologists Fried and Engelhardt. One advantage of using the notion of moral perspectives to structure their views is to show clearly what it involves when each attempts to justify his views as well as exactly where their disagreements occur.
II. Principlism: Beauchamp and Childress

Principlism is a name used by some critics of Beauchamp and Childress to signal their principle-based moral approach (Clouser and Gert, 1990). But Beauchamp and Childress have adopted the name to connote their strategy (Beauchamp, 1995; Childress, 1997). Although one author argues that, from the first through the fourth edition of their *Principles of Biomedical Ethics*, they have significantly changed their views (Emanuel, 1995), this section holds that their views maintain the same moral perspective in every edition. One reason for exaggerating differences throughout the different editions of the book is a failure to see that what they provide is a moral perspective, rather than as abstract moral theory. This section shows that their principlism illustrates a particular moral perspective that incorporates their formal generalizations, metaethical beliefs, and shared exemplars.

1. Formal Generalizations

Although Beauchamp is a rule utilitarian and Childress a rule deontologist (Beauchamp and Childress, 1979; 1983, pp. 40-41), they have formulated the same four principles for regulating health care and research ethics. These principles are: respect for autonomy, beneficence, nonmaleficence, and justice. The principle of autonomy states that, in its negative form, “autonomous actions should not be subject to controlling constraints by others” (1994, p. 126). The principle of nonmaleficence claims that everyone has an obligation not to inflict harm intentionally (p. 189). The principle of beneficence asserts an obligation to help others further their important and legitimate interests (p. 260). And
the principle of justice asserts a group of norms for distributing benefits, risks, and costs fairly (p. 38; pp. 330-331).

These are formal generalizations. One does not know the concrete contents or requirements of these principles until they have been specified. Much depends on how one understands “autonomy,” “harm,” “interests,” “intentionally,” “legitimate,” and so on. This partly explains why Beauchamp and Childress can easily agree on beginning with these principles to build their bioethical approach, although they advocate different moral theories.\(^60\) Indeed, they claim that “theories are rivals over matters of justification, rationality, and method, but they often converge on mid-level principles” (p. 102; pp. 109-111).

2. Metaethical Beliefs

There are some different metaethical commitments which separate Beauchamp and Childress regarding the nature and justification of these principles. First, as a utilitarian, Beauchamp understands these principles as those which generally will maximize welfare. They are the right moral principles for guiding health care and biomedical research because they generate the best consequences. On the other hand, as a deontologist, Childress understands these principles as morally right-making conditions. General conformity with them may lead to the best consequences, but the rightness of them as moral principles is independent of any consequences they may bring about.

\(^60\) According to one source (Campbell, 1989, pp. 121-122; p. 141, note 5), Childress should have preferred to have different formal generalizations from those expressed in their jointly authored book. His principles should be: respect for persons (rather than autonomy), nonmaleficence, beneficence, utility, and justice. The fact that he chose to compromise in this regard also shows that these formal generalizations do not matter essentially in concrete cases or problem-solutions.
However, their disagreements lie only at these abstract levels. As to the concrete methods of justification with regard to moral judgments, rules, principles, and theories, they both agree to a coherence theory of justification (1994, p. 23). They agree with John Rawls that justification is “a matter of the mutual support of many considerations, of everything fitting together into one coherent whole” (Rawls, 1971, p. 21). Accordingly, their method of justification is like the strategy of reflective equilibrium addressed and used by Rawls (1971, p. 48) as well as the procedure of courts-reasoning discussed by Joel Feinberg (1973, pp. 34-35).\footnote{As the following section shows, Peter Singer is strongly critical of the strategy of reflective equilibrium.}

On the one hand, if a principle commits one to an antecedently unacceptable judgment in a particular case, then one should modify or supplement the principle so as to render it coherent with one’s particular and general beliefs taken as a whole. On the other hand, when a well-founded principle indicates the need to change a particular judgment, the overriding claims of coherence require that the judgment be adjusted (B&C, 1994, p. 23).

The crucial elements for this method of justification are “considered judgments,” “the moral convictions in which we have the highest confidence and believe to have the lowest level of bias” (p. 20). They admit that their approach begins with “a particular set of beliefs - the set of considered judgments (also called self-evident norms and plausible intuitions) that are acceptable initially without argumentative support” (p. 24). They also hold that these convictions are embedded in our common moral commitments regarding the moral life. In fact, they identify their approach as a “principle-based, common-

morality theory” (p. 100). They concede that their strategy “constructs principles and rules from considered judgments in the common morality” (p. 101). They also claim that there are some “safeguards” for constructing moral concepts and principles (p. 24). One is the resemblance condition, which requires that a moral account remain faithful to (resemble) the principles and concepts that provided the starting point for that account. The other is universalizability, which demands that if a moral requirement applies to one circumstance, it applies to all other circumstances that are not different from the initial circumstance in any morally relevant respect (pp. 24-26).

3. Exemplars

In their PBE Beauchamp and Childress devote a chapter to each of their four principles. These chapters offer their shared exemplars. I will only focus on their chapter 6 on the principle of justice and their account of health care justice to explain their shared exemplars in this respect.

(1) Interpretations of the Principle of Justice

Following W. D. Ross, Beauchamp and Childress treat their four moral principles as prima facie binding norms, without assuming any predetermined ranking of them. But when these principles come into conflict with each other, one principle can be justified to override another if adequate reasons are given. This is called balancing (pp. 32-34). They also admit that their principles must be specified as to their contents as well as about what counts as an instance of a principle. If a principle lacks such specificity, they concede, “it is empty and ineffectual” (p. 28).
They specify their principle of justice in several loosely related ways. First, they observe that the Aristotelian principle of formal justice ("equals must be treated equally and unequals must be treated unequally") does not offer real guidance, because "it provides no particular respects in which equals ought to be treated equally and provides no criteria for determining whether two or more individuals are in fact equals" (p. 328). Therefore, second, they understand that they need material principles of distributive justice to direct public health care policies. They notice that the following different material principles have been proposed and applied (p. 330):

a. To each person an equal share

b. To each person according to need

c. To each person according to effort

d. To each person according to contribution

e. To each person according to merit

f. To each person according to free-market exchanges

They hold that "each of these material principles identifies a prima facie obligation whose weight cannot be assessed independently of particular circumstances or spheres in which they are especially applicable" (p. 330). Now their principle of justice has been specified as equivalent to these mutually incompatible material principles with regard to distributive justice. The reader would then expect them to offer further specificity thus determining which principle should apply to which particular circumstance or sphere. However, this is not what they do. Instead, they turn to a brief discussion of four moral theories of distributive justice: utilitarianism, libertarianism, communitarianism, and egalitarianism. Their conclusion is that each of these theories "is a philosophical
reconstruction of a valid perspective on the moral life, but one that only partially captures the range and diversity of that life” (p. 387). It seems that, finally, their work of specification ends with the contentions that one should (1) judge which specific aspects of a situation are morally relevant and which material principles ought to be dominant in the situation, and (2) try to find a convergent conclusion of these theories with regard to the situation.

(2) Concrete Problem-Solutions

As shown in Chapter Three, Beauchamp and Childress’ account of health care justice displays a good example of their shared concrete problem-solutions within their moral perspective. The problem is what a just pattern of health care allocation is in a country like the United States. Their solution is a two-tiered health care system in which government ensures the first tier of a decent minimum of health care based on need, while individuals are allowed to purchase better health care at their own expense. They offer several reasons and arguments for this solution.

In addition to their chapter on justice in their PBE, they have each authored at least one long article on the issue (Beauchamp: ‘The right to health care in a capitalistic democracy,’ 1991; Childress: ‘Rights to health care in a democratic society,’ 1997). They both argue for the right to a decent minimum of health care. Reading these essays carefully, one can specifically see how they locate the problem, what their basic moral starting points are, how they evaluate health care facts, how they balance different

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62 In his article, Childress argues for a political-legal right to health care rather than a moral right, although he states that “I believe that there are strong arguments for a moral right to health care within democratic societies” (1997, p. 239).
considerations, and so on. A key that enables them to lead to their solution lies in their concrete moral commitments with respect to the issue.

(3) Specific Moral Commitments

The specific moral commitments within their moral perspective should be their “considered judgments.” Since they claim that their principles and rules are derived from considered judgments embedded in the common morality, considered judgments are extremely important for their approach. However, only in passing do they mention some considered judgments that Rawls originally proposed, such as judgments about the wrongness of racial discrimination, religious intolerance, and political representation (1994, pp. 20-21). Throughout their discussion of respect for autonomy, nonmaleficence, beneficence, and justice, they never clearly formulate their shared considered judgments. Here I attempt to locate their considered judgments in supporting their account of health care justice.⁶³

First, the outcome of the distributive shares of health care decided by the lotteries of biological and social life is unfair from a moral perspective (unfair-lottery judgment). As previously discussed, a fair-opportunity rule is originally addressed by Rawls and used by Daniels and many others. Beauchamp and Childress support this rule and share the considered judgment regarding the unfairness of health care distributions. This judgment directs them to argue for a right to health care.

Second, a pattern of health care allocation that demands a great drain on social resources is considered “unreasonable” (unreasonable-drain judgment) (1994, p. 353).

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⁶³ The burden should be on Beauchamp and Childress to determine whether this list of their considered judgments in the regard is sufficient and/or accurate.
This judgment enables them to adjust their argument for a right to health care to an argument for the right to a decent minimum of health care. Finally, the current American health care system is in particular held unfair because of the reliance on employers for financing the system (unfair-reliance judgment) (1994, p. 349). Roughly 37 million Americans lack health insurance of any kind, many of whom are employees of small firms for whom the costs of maintaining insurance are much higher than for large employers. They are very impressed by and critical of this situation (Beauchamp, 1991; 1994, pp. 348-349; Childress, 1997).64

4. Comments

Many critics of Beauchamp and Childress' principlism focus on the structure of their principle-based approach. Rival approaches have been proposed, such as theory-based (Clouser and Gert), case-based (Jonsen and Toulmin), narrative-based, virtue-based, and so on. From the strategy of moral perspectives that this chapter takes, however, what is important is not the general form of an approach, it is the content that really distinguishes one moral approach from others. In particular, it is not important to find what principles or theories have been set up in a general form or what metaethical beliefs are assumed in the theory. Those are certainly related issues. However, it is vitally important to examine what interpretations, rankings, specifications, and balancing are integral to their formal generalizations, to understand its concrete moral problem-solutions or case-analyses, and to find out its concrete moral commitments. In short, it is more useful to

64 Other considered judgments may be teased out from their arguments such as the considerations of collective protection and the practical convergence of different theories of justice. But these are extremely weak arguments. They surely have some clear considered judgments implicit in these arguments that need to be disclosed.
consider a bioethical approach as reflection of a particular moral perspective in order to see clearly what its content is and how it defends itself.

This exploration of Beauchamp and Childress' principlism shows that their principlism is a restructure of a particular moral perspective with specific exemplars: its shared interpretations, problem-solutions, and concrete moral commitments. By analyzing their approach in this way, one can see how their approach differs from others and why they cannot justify their approach without begging the question regarding the content of their particular principle interpretations and problem-solutions, as well as their particular moral commitments.

III. Utilitarianism: Singer vs. Friedman

1. Formal Generalizations

Singer's formal generalization of his theory is a utilitarian principle: the principle of equal consideration of interests. This principle requires that one must take into account the interests of all those affected by one's decision, no matter whose interests they are. As we presented in Chapter Two, Singer holds that this principle naturally leads to the utilitarian conclusion that one ought to adopt the course of action that most likely maximizes the interests of all those affected.

On the other hand, Friedman's formal generalization of his moral belief is a doctrine of natural rights: "there exist natural rights that...can be described in terms of entitlements" (1991, p. 261). Everybody has such rights. But they are negative rights - they are "not a complete statement of what I ought to do, but they are a complete
statement of my claims against others and theirs against me” (p. 261). Accordingly, everyone has a right to health in the sense that no one should act so as to harm my health. But it does not mean that others should provide medical care to maintain my health.

Both Singer’s principle of utility and Friedman’s doctrine of natural rights are formal generalizations. They depend upon further interpretations to work out their full meanings and requirements. Although Singer and Friedman begin with different formal generalizations, each may not necessarily object to the other’s formal expression. As a utilitarian, Friedman could not object that one ought to adopt the course of action that most likely maximizes the interests of all those affected. What he argues is that interests can be maximized only through the free market mechanism. In contrast, Singer does not object that everyone has natural rights, as long as the institution of such rights can contribute to the maximizing of interests. What he would contend is that such rights must be grounded in the utilitarian consideration.

2. Metaethical Beliefs

Singer is strongly critical of appeals to a reflective equilibrium as a method to test and/or establish moral theories. By refuting this method, he lays out his own metaethical views regarding the nature and method of ethics. From his view, the method of reflective equilibrium has analogies with scientific method. It gives no sense to the idea of a correct theory other than the theory that best fits the data, after that data has been subject to possible revision in the light of plausible theories (1974, p. 494). Singer points out that Rawls and all his followers are subject to the charge of moral subjectivism because of their appeal to the method of reflective equilibrium.
If I am right in attributing this version of the reflective equilibrium idea to Rawls, then Rawls is a subjectivist about morality in the most important sense of this often-misused term. That is, it follows from his views that the validity of a moral theory will vary according to whose considered moral judgments the theory is tested against. There is no sense in which we can speak of a theory being objectively valid, no matter what considered moral judgments people happen to hold. If I live in one society and accept one set of considered moral judgments, while you live in another society and hold a quite different set, very different moral theories may be “valid” for each of us. There will then be no sense in which one of us is wrong and the other right (p. 494).

Moreover, Singer argues that Rawls misunderstands Henry Sidgwick as also appealing to reflective equilibrium to establish his utilitarianism. Sidgwick, Singer contends, believes that morality is objective. The validity of a moral theory should depend on the self-evidence of the “primary intuition” and the soundness of the reasoning used in its application, not on whether its results match our considered moral judgments (p. 503). The ultimate appeal is to the carefully considered intuitive judgment of the reader, not one which aims at matching a moral theory with the considered moral judgments either of the reader, or of some widely accepted moral consensus (p. 514).

[A]ll the particular moral judgments we intuitively make are likely to derive from discarded religious systems, from warped views of sex and bodily functions, or from customs necessary for the survival of the group in social and economic circumstances that now lie in the distant past. In which case, it would be best to
forget all about our particular moral judgments, and start again from as near as we can get to self-evident moral axioms (p. 517).

Accordingly, Singer distinguishes considered moral (intuitive) judgments from self-evident moral axioms. Our ordinary intuitions or judgments are inevitably distorted by our religious or other prejudices. On the other hand, as Sidgwick argues, there are "real ethical axioms - intuitive propositions of real clearness and certainty" (ME, p. 373). Sidgwick finds three, and only three, genuine axioms: impartiality (whatever action any of us judges to be right himself, he implicitly judges to be right for all similar persons in similar circumstances), prudence (the idea of impartial concern for all parts of our conscious life), and objectivity\(^{65}\) ("as a rational being I am bound to aim at good generally, ...not merely at a particular part of it") (pp. 510-511). Accordingly, Singer concludes that a better ethical method than that of reflective equilibrium is:

- search for undeniable fundamental axioms; build up a moral theory from them;
- and use particular moral judgments as supporting evidence, or as a basis for ad hominem arguments, but never so as to suggest that the validity of the theory is determined by the extent to which it matches them (p. 517).\(^{66}\)

It is not clear how Friedman views the nature of morality. He is a utilitarian. It might be misleading for him to claim that his view of natural rights is close to Nozick's. Nozick is a deontological libertarian. Natural rights exist because they are right-making conditions, independent of outcome consideration. However, as a utilitarian, Friedman should argue

\(^{65}\) "Objectivity" is my own summarizing term for Sidgwick, not his own.

\(^{66}\) In Singer's well-known article 'Famine, affluence, and morality' (1972), he is evidently using the strategy of fundamental axioms to build his arguments for our moral obligation to prevent others from starving.
for natural rights based on a utility calculation or a consideration of consequence. He
does argue that natural rights correspond fairly closely to the laws of a pure free market

3. Exemplars

(1) Interpretations of the formal generalizations

Singer’s detailed explanation of his utilitarian principle is manifested in his particular
argumentation in relation to a wide range of ethical issues, including the issues of animal
rights, world famine, defective newborns, health care allocation, and so on. Friedman’s
explanation of his doctrine of natural rights and economic efficiency is found in his
argument about private ownership and operation in general and health care allocation in
particular.

There exists a sharp contrast between Singer and Friedman regarding their
interpretation of their formal generalizations. As utilitarians, both agree that morality
requires maximizing interests. However, for Singer, individual freedom has to be
restricted in order to maximize interests, while for Friedman, individual freedom must be
maximized to maximize interests. Accordingly, Singer stresses that the free market must
be restricted and government intervention must be used, while Friedman emphasizes that
government intervention must be limited and avoided as far as possible.

(2) Concrete problem-solutions and paradigm case-analysis

Chapter Two showed how Singer argues why only a single-tier, all-encompassing, and
state-run health care allocation can maximize the interests of society. Chapter Three
revealed why Friedman contends that medicine must be treated as a commodity like food or housing and that only by the free market mechanism without government intervention can health care allocation obtain the best consequences. These are concrete problem-solutions each offers regarding health care distribution.

Singer also provides a paradigm case-analysis: blood supply. He uses this case as an example to argue why the free market does not fit health care allocation. Should blood for medical purposes be obtained from voluntary donors and commerce in blood be prohibited? Or should both voluntary donation and commercial transactions are allowed? In countries like Britain, commercial transactions are prohibited and only voluntary donations are encouraged, while in other countries like the United States both voluntary donation and commercial sales are available. Many argue, Singer concedes, that even if commercial dealing in blood is allowed, anyone who wants to give can still do so. Prohibiting commerce in blood is a denial of the freedom of those who wish to sell; permitting commerce, on the other hand, does nothing to limit the freedom of those who wish to give. Since freedom is a goal that most of us value, this seems to be a strong argument against prohibition of commerce. However, Singer argues that this is not the case.

This notion of freedom is superficial in the most literal sense of the term; it refuses to probe beneath the surface. In the particular case we are considering, this notion of freedom is satisfied in the American situation because a person can give blood voluntarily if he chooses to do so. It is, in this notion of freedom, irrelevant to consider that, ... the existence of a commercial system may discourage voluntary donors. It appears to discourage them, but not because those
who would otherwise have donated their blood voluntarily choose to sell it instead if this alternative is available. In fact, donors and sellers are, in the main, different sections of the population. Rather, voluntary donors are discouraged because the blood's availability as a commodity, to be bought and sold, affects the nature of the gift that is made when blood is donated. If blood is a commodity with a price, to give blood seems merely to save someone money; it has a cash value of a certain number of dollars. As such, the importance of the gift will vary with the wealth of the recipient. If blood cannot be bought, however, then its value as a gift depends on the recipient's need. Often, it will be worth life itself. Under these circumstances, giving blood becomes very special, an act of providing for strangers, without hope of reward, something they cannot buy and without which they may die. The gift relates strangers in the community in a manner that is not possible when blood is a commodity (1985, p. 9, italics original).

In short, from Singer's view, allowing commerce in blood makes altruism unnecessary, and "so loosens the bonds that can otherwise exist between strangers in the community" (p. 10). If a community puts a money value on everything, it will restrict ways in which strangers can help each other and set the interests of one person against those of another. This will make a "materialistic community in which each looks out only for his own interests" (p. 11). Hence, Singer concludes, a community may legitimately restrict the freedom of individuals to sell blood in order to encourage the development of altruistic attitudes that are important to the best interests of the community.
Friedman also considers some cases that seem to suggest that the government should regulate or redistribute health care. A prominent case is the problem of the poor. The traditional standard utilitarian argument for redistribution begins with the belief that, for a given individual, the marginal utility of income declines as income increases. This follows that, on average, the poor have a higher marginal utility for income than the rich. Hence total utility will be increased if the government provides free medical care (or housing, or food, or money) to the poor at the expense of the rich. Thus the government should mandate such redistribution.

Friedman provides three reasons to refute this argument. First, it is not necessarily true that the marginal utility of income is correlated inversely with income. It is plausible if income is got by inheritance, lottery, or some other chance mechanism. But it is implausible if different income is the result of different effort. "An individual who greatly values the things that money buys will be more willing than others to give up other goods, such as leisure, in order to get income, so he will, on average, end up with a higher income" (p. 280). In such a case it is more reasonable to assume that income and the marginal utility of income are positively correlated.

Second, this argument does not have special relevance to medical costs or allocation, unless different medical bills are an important cause of inequalities in the marginal utility of income among individuals. From Friedman's view, this is not always the case (pp. 280-281).

Third, even if we should prefer outcomes that are biased towards the poor, everything else being equal, we have yet to decide whether we should favor political or private market. According to Friedman, both available theory and actual evidence are not
very clear about this issue. For one thing, public choice theory does not offer any clear answer as to whether government intervention is likely to increase or decrease inequality, to distribute to the poor or from them:

On the one hand, votes are more evenly distributed than income, which should tend to make the political market more egalitarian than the private market. On the other hand, many of the characteristics that give groups and individuals political influence are closely related to income. Education reduces information costs, labor skills differentiate their possessors into (relatively) concentrated interest groups, stockholders have their interest represented by well organized firms and skilled (hence highly paid) workers by well organized unions, and so forth. So far as theory is concerned, it is difficult to predict whether the political system is more likely to transfer money down the income ladder or up (pp. 281-282).

In addition, the actual evidence is also unclear. For Friedman, some government programs, such as food stamps, welfare, and the like, are meant to help the poor. Some programs, such as state subsidies to higher education, are actually to help the not-poor at the expense of the poor. Still other programs, such as Social Security, have ambiguous effects. “Poorer individuals, on average, start work earlier and die earlier, hence pay more years and collect for fewer” (p. 282). Hence the program may have harmed rather than benefited the poor.

(3) Specific moral commitments
Throughout Singer’s discussion of national health care service and his argument around blood supply as well as Friedman’s discussion of medicine as a commodity and the so-
called problem of the poor, they have the same utilitarian moral commitment: we are morally obligated to seek the best consequences for our community (and ideally, for the whole world). But just as they judge many issues differently, they hold different concrete moral commitments. One of Singer’s adamant moral commitments is that, in order to achieve the best consequences for a community, individuals’ free choices (especially with regard to vital things such as health care and blood supply) must be limited; instead, the best consequences for the community can be realized only through equal distribution of the vital things by government intervention, without leaving them to the free market.

On the other hand, one of Friedman’s firm moral commitments is that we must let the free market work to lead to the best consequences; any government intervention is suspect at best and disastrous at worse.

Finally, Singer has a strong commitment to egalitarian consideration of interests, while Friedman does not. For Singer, it seems that total interests cannot be maximized without equally realizing everyone’s interests. This is why he argues for radical government intervention and regulation in order to maintain equal interests for everyone. In contrast, Friedman cares about total utility and efficiency without any particular egalitarian concern. For him, only a free market can bring to individuals the best consequences.

4. Comments

Although both Singer and Friedman are utilitarians, they demonstrate two incommensurable moral perspectives. While they hold the same general utilitarian understanding of social justice (namely, the best consequences for society), their different
particular concerns and commitments take them to different conclusions regarding health care justice and other issues. This shows again that concrete commitments and values are more important than formal generalizations in moral reasoning and analysis.

IV. Contractarianism: Veatch vs. Daniels

1. Formal Generalizations

At the first glance, Veatch's and Daniels' formal generalizations of their accounts of just health care distribution are quite similar. They are both egalitarian. As illustrated in Chapter Two, for Veatch, justice in health care allocation consists in maintaining the principle of equality of objective net welfare, while for Daniels, health care allocation should be governed by the principle protecting fair equality of opportunity. Although these formal generalizations have a similar egalitarian outlook, it turns out that Veatch and Daniels hold different moral perspectives. This will become clear when we explore the exemplars that they each respectively hold.

2. Metaethical Beliefs

Both Veatch and Daniels are contractarians in the sense that they want to use contract theories to justify morality. Daniels follows Rawls in adopting a hypothetical

\[67\] However, Veatch distinguishes "relative" and "true or strict" versions of egalitarianism. He considers "a principle of justice to be a true or strict egalitarian principle if it holds that opportunities for equality per se are called for whereas a principle of justice that affirms allocations that redound to the benefit of the worst of groups will be termed relatively egalitarian" (1998, p. 457, italics original).
contractarian strategy to justify a theory of justice. But Veatch is unclear regarding whether he is an actual or hypothetical contractarian.

Veatch notices that many people claim that a universal base for morality can be discovered. For those who believe that there is a divinely created moral order or a natural moral law, it remains only for people to have it revealed to them or to develop a way to discover it. However, Veatch observes, not all agree that a universal moral basis exists objectively for us to find by revelation, awareness of natural law, reason, or our moral sense. Many believe that such a basis can only be invented by a social contract (1981, pp. 114-117). Now, for Veatch, the most critical problem is whether those who want to discover a foundation for resolving moral controversies can reconcile their approach with those who want to invent a framework by creating a social contact. Veatch proposes "a synthesis contract theory" to resolve this problem. As he sees it, for those who favor the idea that a universally applicable moral framework can be discovered, the contract must function as an epistemological tool for discovering the moral order instead of, or in addition to, a way of inventing a moral order. Assuming that there is an order to be discovered, humans would come together as a moral community through collective reasoning, perceiving, or the receiving of revelation to discover the moral structure that will provide the basis for their community (Veatch's examples are Christian denominations). On the other hand, for those who do not favor the idea that a universal basis can be discovered, they come together to invent the basic principles constitutive of their society for their self-interests. According to Veatch, they can be successful only to the extent that they respect each person's liberty (the assumption of individual liberty) and treat everybody's interests equally (the impartial point of view, or "the moral point of
view"), becoming an approximation of the ideal observer or the ideal rational agent. In short, Veatch argues that a universal moral basis can be established through a synthesis contract strategy (pp. 120-126).

For one group it is a very sophisticated technique based on enlightened self-interest. For the other, it is the best epistemological tool it has for discovering the moral order. For the former group the principles are agreed to because they reflect self-interest; for the latter it does not make much sense to ask why they are agreed to, they simply are. (Reason dictates so, or the moral sense perceives them so...) (p. 125)

It seems that Veatch argues there are two types of contract that converge into the same synthesis contract. One type is a hypothetical contract made by the former group of people (who do not accept the idea that a universal moral basis can be discovered) when they take an impartial point of view. The other type is an actual contract to which either people simply agree (reason dictates so...) or they agreed in the past (such as the original Christian covenants between God and man) (pp. 123-124). 68

From this synthesis contract method, Veatch argues, a set of principles will be articulated that will constitute the foundation for morality. Then a second contract between society and a profession such as the medical profession can be spelled out based on the first contract. Finally, individual professionals and lay persons can spell out further the terms of their relationship within the context of the first two contracts. The result is a triple-contract theory of medical ethics (pp. 127-138).

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68 There are puzzling questions for this point of view: if individuals already agreed in the past, why do they need to come together to do it again? On the other hand, why should self-interested people take an impartial point of view?
Daniels follows and defends the Rawlsian hypothetical contract as a justificatory device. In particular, he believes that a moral theory can be justified by what Rawls has called the method of wide reflective equilibrium (1996, p. 21; Rawls, 1971, p. 49). Daniels argues that the contract is "a special feature of a particular wide reflective equilibrium" (1996, p. 48). This method of wide reflective equilibrium consists of an ordered triple set of beliefs held by a particular person, namely, (a) a set of considered moral judgments, (b) a set of moral principles, and (c) a set of relevant background theories. One begins with those considered moral judgments in which one is confident, then proposes alternative sets of moral principles that have varying degrees of "fit" with the moral judgments, and finally advances philosophical arguments derived from a set of relevant background theories to bring out the relevant weaknesses and strengths of the alternative sets of principles and choose a favored set of principles. Thus, by working back and forth, making adjustments to one's considered judgments, moral principles, and background theories, one arrives at an equilibrium point that consists of the ordered triple (a), (b), and (c) (1996, p. 22; pp. 48-49). Hence, the contract apparatus is not self-evidently acceptable. Rather, philosophical arguments derived from relevant background theories must persuade us that it is a reasonable device for selecting between competing conceptions of justice.

There are two important points that Daniels emphasizes regarding such a wide reflective equilibrium. First, the theories in (c) must show that the principles in (b) are more acceptable than alternatives on grounds to some degree independent of (b)'s match with relevant considered moral judgments in (a). Without such an independent support, there would only be a narrow, rather than wide, reflective equilibrium (p. 22; p. 49). For
example, Rawls' two principles of justice in his theory of justice gain support not only from our initial considered judgments, but also from a number of relevant background theories, in particular, from a theory of the person, a theory of procedural justice, general social theory, and a theory of the role of morality in society (including the ideal of a well-ordered society) (p. 23). Second, the theories in (c) cannot just be reformulations of the set of considered moral judgments in (a). They must reach beyond the range of the judgments in (a). Specifically, a set of considered moral judgments that supports (c) must be disjointed from the set in (a) that supports the principles in (b).⁶⁹

Daniels concedes that convergence in wide reflective equilibrium is neither a necessary nor a sufficient condition for claiming that we have found objective moral truths. There may be other ways to pursue moral truth. On the other hand, there is the possibility that there may be consensus on moral falsehoods. However, Daniels claims that "such convergence may constitute evidence we have found some [truths]" (p. 35, italics original).

3. Exemplars

(1) Interpretations of the Principle of Justice

Veatch proposes six basic principles of medical ethics, including one consequentialist principle (the principle of beneficence), and five nonconsequentialist principles (the principles of contract keeping, autonomy, honesty, avoiding killing, and justice). Veatch

⁶⁹ Here there are at least two problems for Daniels: first, given that there are so many (innumerable?) different background theories, how do we know which theories are relevant and which are not? Second, it seems that the issue eventually has to depend on an artificial decision regarding whose considered moral judgments, what principles, and which background theories to pick out. Wide reflective equilibrium may remain a narrow circle of question-begging strategy.
sets a lexical priority to his nonconsequentialist principles: the nonconsequentialist principles must be satisfied as prior necessary conditions before the principle of beneficence can play a role in medical decision. In other words, the result of balancing the nonconsequentialist principles is lexically ranked over the result of balancing the consequentialist principles. On the other hand, the five nonconsequentialist principles are equally binding. No lexical ordering can be given to them. They have to be balanced against each other if they involve conflicts in concrete situations (1981, pp. 291-305). For instance, the balancing of the principle of justice (which requires equal welfare) and the principle of autonomy (which protects personal voluntary choices) in health care allocation leads to the requirement of equal opportunity, rather than equal outcome, of health as far as possible (1981, p. 278).

Daniels' principle of justice is equality of fair opportunity. For him, this principle has a crucial implication for health care, namely, that one should maintain the normal species functioning of everyone in society. Because the species-normal functional organization of human beings, according to his understanding, is independent of individual values and preferences, health care needs based on normal functioning can be established without referring to any individual or social value system. Because impairment of normal functioning through disease or disability constitutes a fundamental restriction on individual opportunity relative to the normal opportunity range were he healthy, the principle of equality of fair opportunity requires society to provide health care to everyone, if it wants to maintain equality of fair opportunity.

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70 Many might think that it is not wise to give a strict priority to nonconsequentialist principles over consequentialist principles. However, Veatch retains his faith up to the present. See his 1995.
(2) Concrete problem-solutions and paradigm case-analyses

For Veatch, although the principle of justice requires equality of net objective welfare, it is not the only principle involved in health care allocation. Other principles, especially the principle of autonomy, also involve decision-making in health care. Actual health care decisions must be made by balancing these equally binding principles. This leads Veatch to form two important problem-solutions.

The first, as we mentioned in Chapter Two, regards voluntary risks to health. Some people voluntarily engage in behaviors that are harmful to their health, such as smoking, compulsive eating, excessive drinking, etc. Should smokers, for example, be required to pay for the costs of their extra health care required over and above that of nonsmokers? Within Veatch’s context of multiple principles, although the principle of justice requires equality of net objective welfare without involving other factors, other principles do. In particular, the principle of autonomy preserves individuals’ voluntary choices and assumes their responsibilities for their choices. Adding this principle to the context of health, what egalitarianism wants is only the requirement that each individual is entitled to an equal opportunity for a chance to be as healthy, insofar as possible, as other people. Thus the question here is what just treatment is of those who have had opportunity and have not taken advantage of it. A special tax may be levied on tobacco in order for smokers to pay for the extra risks to their health (1980).

Second, Veatch supports government guarantee of universal access to basic health care. Given that health care resources are limited, he argues for an insurance policy with
a specified range of coverage.71 However, although the principle of justice supports universal access to basic health care, Veatch contends, there is no good reason for a single basic package for everybody, namely, for everybody receiving care from a single-list plan. From his point of view, “however efficient it is to administer such a single-list plan, it is inherently unfair” (1997, p. 156). Instead, he supports a universal health plan with single payers and *multiple lists*.

Why is it unfair to administer a single-list plan? This is because, Veatch argues, health benefits inevitably have a normative nature. Although medical science can tell us what the predicted effects will probably be of an intervention, it cannot tell us whether the outcome is worth pursuing. Every medical choice involves some sort of normative judgment about what counts as a valuable or good outcome. Even if one accepts an objective theory of the good, it is not medical expertise that gives one the ability to know authoritatively which outcomes are good and which bad. That power rests only with experts in axiology (objective values). In a secular pluralistic world, Veatch claims, “we have no ready means available for identifying who those experts are” (1997, p. 157). Thus, no definitive authority exists for generating lists of treatments that produce good outcomes for everyone. Moreover, because individuals hold different and incommensurable values, preferences, and expectations, there cannot be a consensus over any single list of treatments.

There are likely to be serious moral disputes about which services should go on the list. Some feminist groups would surely argue that abortion is a necessary

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71 In his 1991, Veatch considers a $2000 health care package per person per year; in his 1997, he proposes a fixed premium of $3500. In both places, he concedes that the exact level is somewhat arbitrary (1991, p. 93; 1997, p. 160).
service of immeasurable value while some males and post-menopausal females would see little if any value in it and those in the pro-life camp would consider such interventions to be a terrible wrong. The last group would likely protest even to the point of violence to ensure that their insurance contributions or tax dollars did not go for this evil. Others would challenge the moral legitimacy of including aggressive cancer surgery, hospice care, liver transplants for alcoholics, circumcision, blood transfusions, or, in the case of Christian Scientists, virtually all medical interventions. Even for those treatments or procedures about which there is no open moral controversy, different people in different subcultures will evaluate the benefits very differently. Some will give high priority to the mental comfort from yearly mammogram for 40-year-old women while others would consider that benefit too trivial to justify the monetary cost and the radiation risks. Some would give high priority to battles to preserve the lives of patients with metastatic cancer while others would consider palliation a more appropriate investment (1997, p. 158).

Accordingly, Veatch argues, if a single list is set down, it will give those closest to the list makers the most value they could get from the funds invested in health care, while those furthest from the center of power will get, for the same premium, a list of services that does not appeal to them nearly as much, and hence is of much less value to them. Therefore, Veatch concludes, there should be multiple lists, rather than a single list, for people to choose. For example, Veatch mentions, a Catholic Health Association list could exclude abortion, sterilization, artificial reproductive technologies, and other morally intolerable services, while leaving money over for other valued services, such as
natural family planning, more compassionate care for the dying, and any other services believed to be particularly fitting, given the group’s system of beliefs and values (p. 162).  

Indeed, Veatch emphasizes, all that egalitarians require is access to a similar level of resources for people similarly situated. They do not insist that social programs (health care programs included) must bring about the same outcome or produce the same amount of happiness in all people. Therefore, there is nothing morally wrong with delivering different services to people who have different, but equally equitable coverage (pp. 160-161).  

In summary, Veatch’s solution to health care allocation shows several characteristics. First, the principle of justice (which for him requires equal net objective welfare) is only one among other equally binding deontological principles. It must be balanced, for example, against the principle of autonomy. The result is only the requirement for equal opportunity to be healthy. Second, he is impressed by diversity in values and does not hold that there are experts in determining objective values. Neither is he optimistic about the possibility of using philosophical argument to resolve controversies in value judgments. Therefore, how much money should be invested in  

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72 The nature of Veatch’s argument is not quite clear. It seems that it is a by-default argument: given that diverse values exist and that there are no authoritative experts in determining objective values, individuals should be left alone with their free choices. On the other hand, however, it seems he is saying that multiple lists are necessary because this is the way to avoid bad social results - avoiding violence or riots in society because a single list would inevitably offend some people (pp. 161-162).

73 Veatch also considers some residual problems with multiple lists, including infinite regression, emergency service, service for protection of others, minors and other incompetents, highly predictable risks, adverse selection based on age, and public vs. private management of the plan. See pp. 162-167.
health care has to be determined somewhat artificially. Moreover, although justice requires universal access to basic health care, there should be multiple lists of services from which people may choose.\textsuperscript{74} Third, he contends there is a real difference between his “true” egalitarian view and the Rawlsian weak egalitarian view.\textsuperscript{75} Finally, he emphasizes individual freedom and assumes individual responsibility for their choices and behaviors based on his principle of autonomy.

Daniels’ principle of fair equality of opportunity is based on his belief in normal species functioning. Deviation from the normal is scientifically discoverable and philosophically defensible. While Veatch’s principle of justice must be balanced against other equally binding principles, such as the principles of autonomy and promise-keeping, which may conflict with the principle of justice, Daniels’ principle of fair equality of opportunity has priority. It is like the principle of freedom within Rawls’ two

\textsuperscript{74} Veatch has provocatively argued for “abandoning informed consent.” As he sees it, clinicians cannot obtain valid consent to treatment because they cannot guess which treatment options will serve a particular patient’s best interests, given that they often hold different values about interests. For him, these guesses could be made accurately if patients were paired with providers who share their deep values. Although this argument may involve a misunderstanding of the nature of informed consent, it shows Veatch’s appreciation of moral diversity. See his 1995a.

\textsuperscript{75} Veatch uses the example of organ sales to show the difference between his “true” egalitarianism and Rawls’ “relative” egalitarianism. Rawls’ maximin theory of justice requires resources to be distributed in the ways that benefit the worst off in the society. However, in special cases where this requirement increases the inequality between the worst off and some who are better off, the Rawlsian theory, Veatch argues, parts company with what Veatch calls the true egalitarianism. For instance, the family of a member of the Ku Klux Klan donated his organs on the provision that they go only to members of the Caucasian race. Such donations can satisfy the maximin criterion. They selectively advantage the recipient of the organs without harming anyone. And everyone who is lower on the waiting list is advantaged by moving up on the waiting list. However, Veatch argues, true egalitarianism holds that such directed donations simply treat people unequally and that, per se, is prima facie unethical, even if it maximizes the position of the least well off. See his 1998.
principles of justice, which has a lexical privilege. It must be satisfied before other social and economic arrangements can be made.

Daniels doubts that individuals who engage in behaviors risky to their health should hold any financial or social responsibilities for their behaviors. As he sees it, social environments play crucial roles in shaping individuals’ habits and actions. It is superficial for individuals to take on the burden of their health problems. It is more fair to maintain everybody’s normal species functioning through universal health care access offered by society.

Daniels is aware of the limits set by scarce medical resources on the application of his principle of fair equality of opportunity in health care provision. Several years ago he conceded that some rationing in any basic health care package is inevitable (1993; 1994). This seems to imply that, because of the limit of medical resources, he has to allow some restrictions on provision of some treatments, even if these treatments can maintain the so-called normal functioning of some individuals. For Veatch, such problems of rationing may be resolved through individuals’ free and voluntary choices. But for Daniels, one should search appropriate solutions through philosophical arguments. This is reflected in his discussion of managed care (Daniels & Sabin, 1997).

In fact, Daniels and his co-author James Sabin in their 1997 article came to argue that “limit-setting decisions are themselves a requirement of justice, since we cannot meet all legitimate needs with limited resources and rapidly improving technologies” (p. 312). From their perspective, the growth of managed care organizations (MCOs) in recent years marks the shift of authority from the patient to private organizations regarding health care decisions. As they see it, “at present considerable authority rests
with MCOs, other insurers, and, more indirectly, with large employers who, in trying to reduce benefit costs, force intense competition among MCOs and other providers” (p. 304). This shift of authority, he argues, raises important questions about the fairness and legitimacy of decisions by these private organizations that limit our medical care. “The legitimacy problem asks why and under what conditions, authority over these matters should be placed in the hands of private organizations, such as MCOs,” while the fairness problem asks “when does a patient or clinician who thinks an uncovered service appropriate or even medically necessary have sufficient reason to accept as fair the limit-setting decisions of a managed care organization?” (p. 305).

Some may argue that there should be no special problem of “legitimacy” involved here, as long as there is clear coverage language in contracts between subscribers and MCOs. Just as there is no such problem facing automobile manufacturers when they make decisions regarding product features and design, MCOs should not face this problem in their limit-setting decisions, either. Daniels calls this argument “the car purchase analogy.” He argues that this analogy fails for three major reasons. First, there is much greater uncertainty involved in markets for medical insurance than in markets for autos. Compared to our knowledge about our needs for autos as well as our information about outcomes, we have greater difficulty in anticipating our needs for health care, and we have not yet developed an adequate technology for reporting on the quality of MCOs. Second, unlike privately choosing one’s vehicles, most Americans receive their health insurance through their employers, who select their employees’ health plans. Finally, more profoundly, we have a widely recognized social obligation to meet people’s medical needs, within reasonable resource constraints, but we do not have a social
obligation to meet people's preferences or needs for autos (pp. 309-311). Accordingly, Daniels contends, since the car purchase analogy does not fit, we should not leave limit-setting decisions entirely to MCOs and our employers. We must inquire into the legitimacy as well as fairness problems. For private health care institutions to acquire legitimacy for their limit-setting decisions, Daniels argues, "they must see themselves, and be seen by others, as contributors to a broader deliberative process that they constructively embrace" (p. 325). They must satisfy the following four conditions in order to place themselves in that role:

A. Decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible.

B. The rationales for coverage decisions should aim to provide a reasonable construal of how the organization should provide "value for money" in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a construal will be "reasonable" if it appeals to reasons and principles that are accepted as relevant by people who are disposed to finding terms of cooperation that are mutually justifiable.

C. There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.

D. There is either voluntary or public regulation of the process to ensure that conditions A-C are met (p. 323).

Clearly, condition A requires openness or publicity. Condition B places constraints on the kinds of reason that can play a role in the rationale for limit-setting decisions - they
must be accepted by all involved as reasonable.\textsuperscript{76} Conditions C and D require and make MCOs’ decisions accountable to a wider scope of deliberations and decisions by society.

Condition B is particularly interesting. While Veatch judges it is right for individuals holding different religious faiths and values to choose different lists of treatment as they see fit, Daniels claims that they are not appropriate reasons to be appealed (p. 331; p. 338).

Reasons must reflect the fact that all parties to a decision are viewed as seeking terms of fair cooperation that all can accept as reasonable. Where their well-being or fundamental liberties or other matters of fundamental value are involved and at risk, people should not be expected to accept binding terms of cooperation that rest on reasons they cannot view as acceptable types of reasons. For example, \textit{reasons that rest on matters of religious faiths will not meet this condition}. Reasonable people differ in their religious, philosophical, and moral views, and yet we must seek terms of fair cooperation that rest on justifications acceptable to all (pp. 338-339, italics added).

Indeed, the ideal for Daniels is to provide persuasive guides to resolve the problems of rationing and limit-setting decisions through philosophical arguments. The solutions thus offered must contribute to the normal species functioning of citizens as far as possible within limited resources.\textsuperscript{77}

\textsuperscript{76} Daniels’ Condition B is quite similar to Rawls’ recent position regarding “public reason.” See Rawls, 1997.

\textsuperscript{77} It seems that Daniels is inclined to resolve all particular issues in health care justice through government intervention. For instance, in his 1988 book, he argues that children do not have any more of moral obligation than any other person in the society to take care of their aged parents. This is because, for him, children do not ask to be brought into the world in the first place. In other words, they do not consent to forming the parent/child
(3) Specific moral commitments

Veatch is committed to the view that justice is equivalent to equality. However, the requirements of justice must be balanced against other equally binding principles, such as autonomy and promise-keeping. Veatch is also morally committed to a lexical priority of deontological principles over consequentialist principles. Consequentialist principles can play a role in moral decisions only after non-consequentialist principles are satisfied.

In contrast, Daniels holds that (1) there is normal species functioning that is independent of any value judgment, (2) disease and disability are such that they impair individuals’ normal functioning, which in turn restrict their normal opportunity range, and (3) justice requires maintaining fair equality of opportunity for each.

4. Comments

The accounts of just health care offered by Veatch and Daniels, at first flush, seem quite similar. Both are contractarian in methodology and egalitarian in requirement. However, when we examine the specific exemplars they each offer, we find that they in fact manifest two quite different moral perspectives. Indeed, they are in many ways incommensurable from each other.

relationship. Thus, from his view, there is a basic asymmetry between parental and filial obligations. The parental obligation of caring for their young children is a “self-imposed” duty, while the children’s filial obligation of caring for their elderly parents is “non-self-imposed” and thus cannot be morally required. Consequently, according to this argument, traditional filial obligation is left either as a responsibility that children may volunteer to undertake or as a moral burden on the whole society. However, other scholars would argue that Daniels has misunderstood the basic moral nature of the parent/child relationship. See Wang, 1999.
V. Deontology: Fried vs. Engelhardt

1. Formal Generalizations

Both Fried and Engelhardt are deontologists. They hold that there are right- and wrong-making conditions in morality, which are prior to any view of the good or commitment to the maximization of the good. One of Fried’s major formal generalizations regarding social justice is his formulation of “a right to a fair share of community’s scarce resources.” In contrast, Engelhardt’s is his cardinal principle of permission.

2. Metaethical Beliefs

As deontologists, both Fried and Engelhardt hold morality to be objective in nature. Fried, following Kant, claims that rights are categorical. As he sees it, the right to a fair share of the community’s scarce resources can be justified by virtue of its richness and overall plausibility (1978, pp. 118). On the other hand, Engelhardt uses a transcendental method of justification to defend his principle of permission. He extends Kant’s transcendental arguments to the sphere of moral experience, contending that one does not need to restrict the realm of transcendental arguments as narrowly as Kant did (1996, pp. 94-95, note 82).

However, Engelhardt argues that transcendental arguments of this kind can only justify a procedural morality, such as the principle of permission. They cannot justify a substantive morality. For example, they cannot establish how the state should use its public resources in health care. In order to obtain detailed and content-full guidance with moral substance, Engelhardt supposes, one must join a religion and "be careful to choose
the right one” (1996, p. ix). He keeps a robust distinction between general philosophical reasoning and religious communitarian narratives.

3. Exemplars

(1) Interpretations of their formal generalizations

As we have shown in the previous chapters, Fried offers a detailed explanation for a right to a fair share of scarce resources. Engelhardt lays out the implications and applications of his principle of permission in the context of health care and related bioethical issues, including health care allocation.

(2) Concrete problem-solutions and paradigm case-analyses

Previous chapters have addressed Fried’s and Engelhardt’s analyses of the role of justice in health care allocation. Here I encapsulate some of their paradigm case-analyses relating to health care distribution.

In Fried’s book, Contract as Promise: A Theory of Contractual Obligation (1981), Fried concedes that conditions for contracts are real promises that ought to be kept. He argues that the moral force behind contracts as promises is individual autonomy: the parties are bound to their contract because they have chosen to be. Society has the general obligation to maintain that contracts that individuals voluntarily bind each other. For instance, there should not be threat of force, use of fraud, etc. These simply dispense from obligation. However, there is one particular type of case where Fried’s treatment reveals significant moral content: his treatment of “bad Samaritans” (p. 109). He gives the two following real cases:
In *Post v. Jones* two whaling vessels came upon a disabled third whaler in remote waters some five thousand miles from the nearest port. Being empty themselves, they held an "auction" and took off the helpless vessel’s full cargo of oil at a small fraction of its landed value. The Supreme Court of the United States upset this enforced sale, and limited the two rescuers to the normally allowed fee for salvage.

In *Batsakis v. Dmotsis* the defendant, desperate for money soon after the German occupation of Greece, borrowed an amount of Greek currency, which in those chaotic circumstances may have been the equivalent of as little as fifty dollars, against her promise to repay two thousand dollars plus normal interest from funds she controlled in the United States. The Supreme Court of Texas enforced the agreement according to its terms (p. 109).

Fried argues that the United States Supreme Court did right in *Post v. Jones*, while the Supreme Court of Texas did wrong in *Batsakis v. Dmotsis*. From his view, the rescuers in *Post* had a duty to help and Batsakis had a duty to share with his destitute countrymen. It may not be right for government to enforce such duties, but it should be appropriate to deny legal recognition to promises exacted in return for the performance of what the promisee was bound to do anyway. "We may hesitate to grant an affirmative action against one who fails to act as good Samaritan. We need not hesitate at all to deny the bad Samaritan his unjust profit" (p. 111).

The underlying principle Fried provides for his conclusion is the same as his argument for a right to a fair share of the community’s resources. It is essentially Kantian.
It is an incorrect conception of liberal individualism to exclude from it any duty to be concerned about and to assist others. The argument has been clear for liberals at least from Kant that indifference to one's fellows devalues our common humanity and so endangers the moral basis for the respect we claim as individuals. If liberalism is distinctive as a moral position, it is in its attempt to accommodate this duty of altruism to an individual's right to define and pursue his own conception of the good without being consumed by the needs of others (p. 110).

At the core of Fried's moral deontology is a balance between a right to seek one's own happiness independent of the needs of others and a duty of altruism towards others. On the one hand, for Fried, this balance denies the legitimacy of any particular positive welfare right, such as a right to basic health care, because enforcing such a right would cause a drain on resources and would thus jeopardize individuals' reasonable pursuit of their good life. On the other hand, however, Fried believes this balance also excludes libertarian thought that government may not impose any particular duty of beneficence on individuals. For Fried, our common humanity requires a basic duty of altruism to each other, and our sharing in a common community grounds a general positive right to a fair share of the community's scarce resources. Accordingly, it was fair that the Supreme Court of the United States allowed only the normal fee for salvage in *Post*, while it was wrong that the Supreme Court of Texas enforced the agreement in *Batsakis*.

Engelhardt, however, would stand ready to defend the decision of the Supreme Court of Texas in *Batsakis* and to oppose the decision of the Supreme Court of the United States in *Post*. He would agree with Fried that, in addition to individual freedom (the
principle of permission, in Engelhardt's terminology), a general duty of beneficence (the principle of beneficence, in his terminology) is also essential to any account of morality. He concedes that the moral life is not exhausted by an account in terms of the principle of permission. Morality must also be recognized as compassing reciprocal web of sympathies, as the principle of beneficence implies. The principle of beneficence can at least indicate that it would be good to benefit persons in need (1996, pp. 107-108). However, Engelhardt argues, because people hold diverse understandings of what should count as actually doing the good as well as regarding how to compare costs and benefits, there does not exist one canonical, content-full principle of beneficence in contemporary pluralist society. Instead, there is a web of moral understandings that sustains concrete, though often complex, commitments to beneficence within different moral communities (p. 112). Most will not reject the principle of beneficence outright, but rather wish only to substitute their principle for someone else's. Accordingly, from a general principle of beneficence, one can at most obtain the basis for a sanction against willing to do evil, because malevolence is the rejection of the good in general. As a consequence, one cannot establish a general secular warrant to use government force to impose on everybody one's (or one's own community's) particular vision of beneficence.

Unlike Fried who finds Kant's argument for beneficence convincing, Engelhardt argues that Kant smuggled unjustified particular content into his moral conclusions about a duty of beneficence. To be specific, Kant confused conceptual contradictions with contradictions in will. In claiming that one cannot without contradiction will to abandon the duty of beneficence, one should recognize that the contradiction involved is only a contradiction in will (i.e., how can you really will to abandon this duty after you
recognize that instances can often arise in which you would need the love and sympathy of others?), not a conceptual contradiction. For Engelhardt, a contradiction in will removes a person from a community with a particular moral sense but does not involve a recognition of morality itself. If one fails to be beneficent in a particular way, one has at most cut oneself off from the beneficent community of that sort. One cannot consistently claim the sympathy and support of beneficent persons if one is unsympathetic to others. For Engelhardt, this reveals that the principle of beneficence does not provide strict moral obligations, but only a reasonable moral ideal (196, pp. 197-109).

Consequently, regarding the rescuers in Post and Batsakis, Engelhardt would argue that we can at most contend that they, in their behavior, had abandoned the principle of beneficence. They did not act against the principle of permission. After all, the rescuers in Post did not try to rob the cargo of oil from another whaler. Neither did they make their contract based on any fraud or deception. They simply exploited the difficult situation of their promisees to satisfy their own selfish interests. The same goes for Batsakis in the second case. In any case, neither Batsakis nor the rescuers in the first case acted on malevolence. Moreover, Batsakis could even defend himself this way: "look, she was in a dangerous situation and was desperate for money to leave. I offered her help, in fact. From my perspective, in order to save one's life, one should be willing to pay more than in an ordinary situation. Put in her shoes, I would think it was fair to give more for help. After all many would give away all their wealth for saving their life. Still, I did not ask for all her wealth. Besides, if the government does not enforce contracts like this, many people like me would not want to offer help in this kind of situation in the future. After all, I forwent money opportunities by lending her money."
Indeed at that time I could have perhaps made more than $2000." In short, Engelhardt certainly agrees that Batsakis' behavior was not praiseworthy. But he would argue that, since government should not coerce individuals to do beneficent things, as Fried agrees, the same logic should require government to maintain contracts based not on beneficent motives, as long as they are not based on malevolent motives, either.  

For Engelhardt, Fried cannot succeed in arguing for a concrete moral duty of beneficence for general society. His purported positive right to a fair share of community's resources cannot be soundly grounded. As we showed in the last chapter, Engelhardt holds that there are as many views of beneficence, justice, and fairness as there are major religions and moral traditions. For example, some religions such as Christianity, Engelhardt argues, should not even take justice as the core of their religious integrity and spirituality. Instead, he sees Christianity as a call to holiness, not a call to justice or equality (1996a).  

This is not to deny that in order to be holy, one must try to be just. However, if one attempts to be holy, then one will pursue justice in a way that will set one apart from the world. Love and mercy will place justice in a new light, indeed transform justice and even set it aside. On the other hand, pursuing social justice in a way that gives greater accent to fairness and equality than to mercy, repentance, and ascetic struggle will integrate more easily with general secular philosophical than traditional Christian concerns (1997a, p. 11).

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78 Suppose in the second case Demotsis did not have funds in the US and as a consequence, Batsakis did not want to lend money to her for her desperate wish to flee. It seems that Fried would not think it appropriate that we should force Batsakis to do so, because Fried believes we cannot force an individual to be good a Samaritan. But why should we force individuals only to make good-Samaritan contracts?
Engelhardt concurs with Friedrich Hayek's observation that Christian ethics becomes engaged in a frenetic search for justice and equality. Just as Christians are "increasingly losing their faith in a supernatural revelation," they "appear to have sought a refuge and consolation in a new 'social' religion which substitutes a temporal for a celestial promise of justice, [so] that they can thus continue their striving to do good" (Hayek, 1976, p. 66; Engelhardt, 1996a, p. 358). From Engelhardt's view, being Christian involves a life of holiness, not merely living justly or morally. It involves a particular view of the deep meaning of the world and of history. Its spiritual commitment is the age-old love which is strengthened in fasting, prayer, and almsgiving. Hence, "Christians should stand out in the context of health care because their lives should be in conflict with contemporary secular assumptions" (1996a, p. 5). For many, managed care raises the special question of how Christian institutions can act morally under financial constraints and maintain their character while under the control of secular managers. For Engelhardt, "this question itself raises the further question as to why health care institutions need even pose this query when there are Christian physicians and nurses who could work less, or Christian men and women who could become sisters and brothers and work for nothing" (1997a, p. 1). From his view,

It would be a simple matter to increase the margin for the mission of Christian hospitals, if every Christian physician and nurse were to work for ten percent less, and if then a significant amount responded. Even more margin for the mission of Roman Catholic hospitals would be available if every unmarried Roman Catholic physician or nurse were invited to consider joining a religious order to serve a Roman Catholic hospital, and if then a good number responded (1997a, p. 8).
Hence, Engelhardt is substantively community-oriented regarding issues of beneficence and justice.

(3) Specific moral commitments

Fried confirms general liberal commitments to individual liberties, plus a general positive right. Engelhardt’s specific moral convictions include two different tiers. At the first tier, he is committed to the moral values and rules of the Orthodox Christianity. However, he contends that these values and rules can only be shared by Orthodox Christian believers (i.e., moral friends). At the second tier, he also holds general liberal commitments to individual liberties among moral strangers in general secular society. But he bases such commitments on and brings them together through his principle of permission. At this level, he holds that it is impossible conclusively to establish any particular account of beneficence by sound rational argument.

4. Comments

Fried and Engelhardt share many ideas. They both argue for individual liberty and limited government. They both hold that it is not feasible to argue for any positive right to health care, even if a very basic right. However, Fried still contends that a particular sense of beneficence can be justified to ground a general welfare right. His account of beneficence is evidently reconstructing a particular Kantian moral perspective regarding moral obligation and distributive justice.

Engelhardt is totally different. He argues that it is impossible to establish a particular sense of beneficence like that offered by Kant in general pluralist society.
Hence, such a large-scale society should be governed only by a procedural principle regarding the authority of action. While Fried clearly reconstructs a particular moral perspective in his argument for specific sense of beneficence as well as his account of a right to a fair share of the community’s scarce resources, Engelhardt does not. His procedural account of social justice in health care does not reflect his Orthodox Christian moral perspective, nor any of other particular moral perspectives.

VI. Conclusion

This chapter uses the notion of moral perspectives to compare the seven different accounts of social justice in health care allocation offered by the theorists we discussed in the previous chapters. It discloses that a normative moral theory, being general and abstract, is insufficient to generate concrete conclusions regarding bioethical issues without introducing further interpretations of the theory. As a result, only a notion that compasses both a normative moral theory and its specific interpretations is able to disclose the entire picture of moral deliberation. I have termed such a notion a moral perspective. Indeed, the role played by normative moral theories in bioethical explorations may have been exaggerated. It is in fact from particular moral perspectives, rather than from abstract moral theories, that specific bioethical conclusions are derived. In contrast with a moral perspective, a normative moral theory only identifies abstract formal generalizations formulated within a moral perspective. It is a moral perspective (in particular, its exemplars), not a moral theory, that accounts for the character of concrete bioethical commitments and approaches. Only moral perspectives are close to the real life moralities. As the forgoing analyses show, we need to adopt this strategy of
an appeal to moral perspectives rather than merely an invocation of moral theories in order to account adequately for how moral theories can actually be applied to health care. Only this augmented strategy can disclose the nature, complexity, and diversity of contemporary moral practice and exploration.

The strategy of moral theories focuses on general formalizations, such as substantive principles of equality or doctrines of rights. Bioethical theorists have approached the allocation of resources to health care on such principles or doctrines as if one could (1) successfully offer philosophical justification for such principles or doctrines, and (2) directly draw specific conclusions regarding bioethical issues from such principles or doctrines without the need of further specification. This is not the case. This essay has shown that no bioethicist we have discussed has afforded convincing argument for his substantive principle or doctrine. Moreover, although such principles or doctrines are substantive and lie at the core of the normative moral theories that the theorists respectively adopt, they remain general and abstract. Without supplying further interpretations, they cannot give rise to concrete bioethical conclusions.

In contrast, the strategy of moral perspectives emphasizes particular exemplars. A moral exemplar is not composed of formal generalizations. Rather, it consists of (1) detailed interpretations of formal generalizations, (2) concrete problem-solutions and/or paradigm case-analyses, and (3) specific moral commitments. As we mentioned in the beginning of this chapter, from the view of a moral perspective, formal generalizations are not essential to moral exploration. We can find the same formal generalizations in different moral perspectives. Different moral perspectives, although they may contain the same formal generalizations, offer different interpretations, involve different specific
moral commitments, and lead to different problem-solutions and/or case-analyses. On the other hand, even if two moral approaches hold different formal generalizations and/or different metaethical beliefs, they can still be the same moral perspective if they share the similar moral exemplars. Indeed, it is moral exemplars, not formal generalizations, that are crucial to a moral perspective. Hence, the strategy of moral perspectives does not focus on formal generalizations. Instead, it pays attention to specific moral commitments, concrete problem-solutions, and detailed interpretations.

The strategy of moral perspectives also differs from the strategy of casuistry proposed by Albert Jonsen and Stephen Toulmin (1988). Their strategy of casuistry focuses on cases. Jonsen and Toulmin argue that real moral deliberations take place in referring to paradigm cases rather than following general rules or principles. This is why, they observe, individuals often reach agreements on particular cases or problems, but not on general principles or theories. However, Jonsen and Toulmin's strategy is defective. It is certainly right to contend that moral explorations and deliberations involve more than following principles or rules because in order to follow principles or rules, one needs to understand the principles or rules. This involves inarticulated or tacit knowledge which goes beyond the scope of principles and rules, as Polanyi illustrated. It is not correct, though, to argue that moral explorations are primarily referring to precedent

79 In working on the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research in the early 1970s, Jonsen and Toulmin found that although the commissioners argued interminably on matters of ethical principles, they agreed quickly about the morality of cases. This state of affairs inspired them to study the traditional moral strategy of casuistry such as that manifested in the Raman Catholic tradition. They proposed the strategy of casuistry in bioethical explorations in compete with the strategy of “principlism” (Jonsen, 1998, p. 82).
paradigm cases. For one thing, there are innumerable relevant previous cases available for one to reflect as a paradigm case for moral guidance. In order to determine which previous case is the paradigm case, one needs to classify and generalize the relevant aspects of previous cases. In order to make such classifications and generalizations, one must appeal to detailed interpretations, specific commitments, and particular principles. That is, one is not able to decide a paradigm case without the functioning of some rules or principles. Consequently, while the strategy of normative moral theory exaggerates the role of principles in moral explorations, the strategy of casuistry overlooks the role of principles and rules.

The strategy of moral perspectives offers a complete geography of moral exploration. Although it recognizes that, in moral deliberation, a crucial role is played by detailed interpretations of formal generalizations (such as moral principles) rather than formal generalizations themselves, it does not downplay the involvement of general moral principles as Jonsen and Toulmin’s strategy of casuistry does. In particular, a moral perspective compasses (1) specific moral commitments and (2) detailed interpretations of formal generalizations implicit in (3) concrete problem-solutions and/or paradigm case-analyses that constitute a real geography of moral exploration and deliberation. Each element is necessary.

While Jonsen and Toulmin notice that individuals more easily agree on the morality of particular cases than on principles, this chapter demonstrates the other side of the coin: although scholars agree on some basic principle (e.g., Singer and Friedman both accept the utilitarian principle to be fundamental) or ethical method (e.g., both Veatch and Daniels adopt contractarianism to build their bioethical theories), they disagree with
each other about specific moral convictions and concrete problem-solutions or case-
analyses. The geography of moral exploration is more complicated than the pictures
painted either by "principlist" or by casuists. It involves both formal generalizations and
particular exemplars. From the strategy of moral perspectives, "principlists" overlook the
huge iceberg of particular exemplars behind the water of formal generalizations, while
casuists downplay the role of general principles implicit in particular exemplars.

From the strategy of moral perspectives, the prospect of substantive accounts of
health care justice looms dim. Looking at the formal principles that people accept, the
ways in which they specify, rank, and balance such principles, their particular moral
commitments, and their concrete problem-solutions and case-analyses, it is clear that
disagreements in morality are extensive and deep because individuals live different moral
perspectives. They may hold the same general principles, but they give different
interpretations to the principles because they hold different specific moral commitments.
All of this leads them to different problem-solutions and case-analyses. They often do
not even hold the same general moral principles, as we have shown in the previous
chapters. Certainly, as Jonsen and Toulmin observe, people sometimes arrive at the same
solutions to particular moral cases even when they do not hold the same moral principles
for regulating the cases or offering the same explanations for their solutions. However, it
is also easy to find other cases in which the hope of "different-principles-but-the-same-
solution" is disappointed. Because people's moral disagreements are extensive regarding
all elements of moralities, it is highly improbable that all will convert to the same moral
approaches to or solutions for issues of health care justice. Because their moral
disagreements reach the very starting points of morality, it is impossible to justify one
particular substantive view regarding justice in health care allocation. Indeed, each substantive account effective reflects a particular moral perspective.

Engelhardt’s procedural account provides a way out. Since his account does not assume any substantive starting point regarding either moral facts or values, his account is not a conceptual reconstruct of any particular moral perspective regarding social justice in health care. Hence, given our definition of a moral account, strictly we should not even term what he offers as a moral account. The principle of permission is established by default. It does not require any substantive moral assumptions. Since individuals hold different views regarding fairness, justice and rationality, and since philosophical argument is unable to establish any view as canonical, moral authority for actions involving others can only be obtained from the permission of others. Surely, Engelhardt’s account includes a formal generalization with a detailed interpretation and concrete problem-solutions and paradigm case-analyses. But his formal generalization is a procedural generalization and his problem-solutions and case-analyses are not based on any substantive moral idea or value. The strength of Engelhardt’s moral account lies not in what one can establish through rational philosophical argument, but in what one can still do with moral authority when one cannot justify any substantive moral view as universally applicable. For Engelhardt, this involves joining the general moral community of mutual respect and peaceable cooperation. Perhaps, we can say that Engelhardt’s account reflects the basic character of this most general moral community. It thus carries a broad moral vision which, through its argument for limited state power as well as its focus on globally non-geographically particular moral communities, shifts our moral concern from the citizens of a state to all the people in the world.
Chapter Six

SOCIAL JUSTICE IN HEALTH CARE: BEYOND CONTEMPORARY WESTERN EGALITARIAN LIBERALISM

I. From National to International Perspectives

The foregoing chapters have shown that how six major substantive approaches to social justice in health care embed their theoretical understandings within the different moral perspectives that provide content and give substance to their respective theoretical apparatus. As has been shown, the theoretical structure of these accounts is incomplete without reference to the exemplars of just allocation and the thick moral assumptions they bring with them. The theories are underdetermined with regard to the policy that the authors of these theories wish to support. These accounts of just health care are best considered the theoretical reconstructions of the particular moral perspectives regarding the issue of social justice in health care.

The foregoing chapters have also shown that each of these substantive accounts of just health care mistakenly focuses on a normative moral theory, ignoring the moral perspective that it in fact manifests. Each attempts to justify its account of proper allocation of health care by invoking a normative moral theory on the assumption that such an account could gain universal acceptance by itself as well as by the derivation of its specific conclusions regarding the appropriate delivery of health services from the moral theory. Chapter Five suggests that it is this assumption that significantly accounts for the dominance of substantive accounts of social justice in health care in contemporary Western societies. This assumption is false. A close examination of these accounts
demonstrate that their specific conclusions regarding proper health care cannot be derived from the moral theory they accept without further interpretation of the theory. A further comparison of the moral exemplars that these accounts include indicates extensive and deep moral diversity and plurality in their moral exploration. The strategy of an appeal to moral perspectives offers a complete picture of moral geography that discloses the narrowness and incredibility of the substantive accounts of just health care for a large-scale pluralist society.

In order to develop further the role of moral perspectives in giving shape to an understanding of social justice in health care, I will now turn to an examination of the Singapore health care system. What I will provide is a theoretical reconstruction of its particular moral perspective regarding health care justice. Just as each of the theorists with substantive accounts under discussion has developed a conceptual reconstruction of a particular moral perspective to bolster its moral credibility, to provide a similar reconstruction of the moral perspective of Singapore is to offer an account of the moral rationality that guides the soft authoritarian capitalistic public policy of Singapore. In part, the health care policy of Singapore can be displayed by outlining the theory of justice at its roots, along with an explanation of the foundational moral practices it takes for granted, such as the institution of the family. In addition to its assumption of family accountability, there lies in the background a thick moral perspective implicit in the Confucian moral tradition.

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80 Indeed, one can regard John Rawls as having developed a conceptual reconstruction of the moral perspective of an East Coast American liberal social democrat regarding the issue of distributive justice, that is, of having provided what must be assumed for a social democratic policy of social distribution to be morally credible.
What follows is offered not simply as a display of a non-Western approach to social justice in health care. The intent is deeper. The goal is to provide a further analysis of the role of moral perspectives in giving full substance to an account of social justice in health care. The analysis of the Singapore approach to health care policy offers a picture of a quite different theoretical foundation, as well as a substantively different moral perspective from those that are often taken for granted in the West. The heuristic of the contrast is offered as a means for giving a further understanding of the interplay among theory, account, and perspective.

In the following I will first introduce Singaporean health care reform instituted in 1984 as well as the underlying principles that guided the reform. I will then compare the Singaporean principles with the American principles formed in the Clinton health plan in 1993. It becomes clear that the moral perspective of contemporary Western egalitarian liberalism provides the substance for the formulation of the American principles, while the moral perspective of the Confucian tradition underlies the Singaporean principles. A major difference between the two particular moral perspective lies in the fact that one seeks equality, while the other pursues harmony. This difference explains why the Clinton reform plan generated an essentially government-responsibility model of health care, while the Singaporean reform successfully led to a family-accountability model of health services. This chapter concludes that, from an international view of health care justice, we must go beyond the popular perspective of the contemporary Western egalitarian liberalism, becoming aware of ever profound moral diversity at the international level.
II. Singapore’s Health Care System: A Compulsory Saving Strategy

1. The Central Provident Fund (CPF)

Singapore is a well-developed modern city-state located just north of the equator and at the Southern tip of the Malayan peninsula. It has a population of 3.3 million, 78% of which are Chinese residents. Since achieving its independence in 1965, Singapore has enjoyed rapid economic growth through successful development of industries and tourism. Per capita income, based on purchasing power parity, reached $20,250 in 1993 (The World Bank, 1994). In 1991 the infant mortality was 5.5 per 1000 live-births, and life expectancy at birth was 76 years (Singapore Ministry of Health, 1993, p. 2).

Unlike most contemporary countries that finance their social security system on a pay-as-you-go basis, Singapore requires people to save for their own retirement and certain other expenses. The institution through which the saving takes place is called “the Central Provident Fund” (CPF). This fund system began as early as 1955, during the colonial government. It has become the primary vehicle for saving for most Singaporeans. As a result, most adult Singaporeans have CPF accounts. Although the accounts belong to individuals, monthly deposits are paid half by employees and half by their employers. Currently, the required savings rate is 40 percent of the salary, up to a ceiling of S$6,000 per month (average annual earnings equal S$30,038; currently S$1.60=US$1.00). This compulsory saving is tax exempt. In 1991, gross national saving was 47.9 percent of GDP (Asher, 1995, p. 5).
Currently, members maintain three CPF accounts: Ordinary, Medisave, and Special accounts. Thirty percent of the saving goes to the Ordinary account, which can be used to purchase a home, make certain investments, purchase certain types of insurance, and pay college education expenses. Six percent goes to the Medisave account (adopted since 1984) for medical expenses. And four percent goes to the Special account for old age and contingencies. Since these accounts direct members to spend money on some goods and services (such as housing, health care, etc.) rather than others, Singapore has targeted certain "merit goods" that are often provided by government in other countries and devised a system that enables most people to purchase these goods by themselves. The result is impressive. For instance, 85% of the Singaporeans own their own homes (Asher, 1995).

2. Medisave

Singapore inherited its health care system from the British. Prior to its 1984 reform, medical services were generally free or at a nominal charge. They were provided mainly by the public sector and financed through general taxes. The private sector played a very modest role. However, like other industrialized nations, Singapore experienced rapid health care cost inflation in the 1970s. The government was pressed to address ways in which to finance the increasing cost of its public hospitals. At the same time, the government recognized some problems in its health care system, such as low efficiency, poor management, physician dominance, and excessive bureaucratic rules. Beginning in 1984, the government decided to cover health care in its program of forced savings, namely, CPF. The government began to require that a certain portion of CPF
contributions be put into a Medisave account to fund hospital care. This is the origin of Medisave (Hsiao, 1995, p. 261).

Obviously, this reform oriented health care in the direction of self-accountability. It also formed a scheme relying in large part on individual self-insurance rather than third-party insurance. Under this scheme, every employee contributes 6-8% of his/her monthly salary (depending on the age group: below 35 years old, 6%; 35-44, 7%; 45 and above, 8%) to the Medisave account. The contributions are shared equally between the employer and the employee. Medisave views most outpatient services as generally low costs, so most people can afford them with their current income or regular savings. Hence, individuals may only use Medisave to pay for hospitalization and a few selected expensive outpatient services for themselves or their immediate family members (spouse, children, or parents) (Asher, 1995).

Currently there are 23 hospitals in total in Singapore, 13 of which are run by the Ministry of Health and the rest are private. Under Medisave, patients have free choice among these providers but pay directly for the services they demand. Hospitals run by the Ministry of Health offer four classes of wards, which receive different levels of government subsidies. Although the standard of medical care is similar across the four classes, they have different accommodations and air conditioning. Class A wards are luxury private rooms that are meant to compete with private hospitals. Patients pay 100 percent of the cost of these wards. Class B1 wards accommodate four patients to a room and patients receive 20 percent government subsidy for these wards. Both Class A and B1 wards are air-conditioned. Class B2 wards have six patients per room and no air-conditioning, but the government offers 65 percent subsidy for them. Finally, Class C
wards have 10-20 patients in the room and are not air conditioned, receiving 80 percent subsidy from the government (Asher, p. 7).

3. Medishield

While most people can use their Medisave funds to cover smaller health care expenditures, many accounts are not large enough to deal with catastrophic medical needs. The government introduced the Medishield account in 1990 to protect people from possible catastrophic medical expenses. Every member of Medisave is automatically enrolled in Medishield with an annual premium, varying with age, deducted from their Medisave accounts. Medishield has a high deductible and covers only hospital expenses and certain expensive outpatient treatments. It has a yearly claim limit of S$20,000 (1993) and a lifetime limit of S$70,000 (Asher, p. 7).

4. Medifund

Singapore government created an endowment fund, known as Medifund, in 1993 to assist persons who are in poverty and cannot pay their hospital bills. This fund is used only to cover the costs of the patients who are hospitalized in Class B2 or C wards. These patients must apply and prove their need for public assistance (Hsiao, p. 262).

Prior to determining their Medisave health care strategy in 1984, Singaporean political leaders put forward the following basic principles to direct their health care reform:

(1) Self-accountability and self-reliance should be stressed;
(2) Free market competition should be deployed whenever possible;
(3) Consumers should have free choice;
(4) Government should be the provider of last resort and offer affordable minimal standards of health care to those who can not afford to pay (Hsiao, p. 261; Kwa, 1994, pp. 30-31).

The Singaporean health care system since 1984 reflects the attitudes and values embodied in these principles. First, the system has shifted the obligation of financing health care from the government to individuals themselves. The mode of free-of-charge medical services offered by the government before 1984 was abandoned. People must save for their health care and pay for it at the point of service. Second, Singapore has since encouraged the development of private hospitals and clinics to compete with those in the public sector. Since the government subsidizes public hospitals (Class B1, B2 and C beds), private sector providers have to compete with these subsidized services by reducing costs and offering better-quality services. Third, patients can freely choose either public or private hospitals as well as among different classes of wards in the public hospitals, as long as they are willing to pay more when they choose higher-level services. Finally, the government offers Medifund to assist those who are proven not able to afford basic medical care (Class B2 and C beds). Notice that the principle here is to "offer
affordable minimal standards of health care,” rather than “needy” or “adequate” medical care.\footnote{1}

It is useful to compare these Singaporean principles with the American principles formed in the President’s Health Security Plan in 1993. Although the plan has not been

\footnote{1 Although most observers concur that the new Singaporean health care system has functioned very well, there is debate regarding whether it has successfully contained health care costs. Indeed, one of the goals of the reform was to control health cost escalation by adopting the strategy of patients’ direct payment. It was conceived that this strategy could avoid the danger of rapid cost inflation in the situation of third-party full health insurance where neither patients nor health care providers are motivated to care about the cost of services. However, some argue that this strategy cannot and did not succeed, because it overlooks some important factors that influence health care competition. From this view, the Singapore experience showed that hospitals largely did not compete on price. Instead, they competed by offering the latest technology and expensive equipments, which appear to be demanded by physicians and accepted by the public as the indicator of quality. They also competed for physicians who could bring a large number of patients to their facilities. Consequently, according to this view, Singapore has failed to contain its health care costs since its 1984 reform. In spite of the high average rate of growth in GDP of 10 percent, Singapore’s health expenditures grew faster, rising from 2.5 percent to 3.2 percent of GDP between 1980 and 1993. Health care expenditures per capita rose at an average rate of 13 percent per year – 2 percent faster than the average before the introduction of Medisave. These figures, this view concludes, cannot be explained away by the upgrading of public hospital facilities (Hsiao, pp. 264-265).

However, other scholars argue that Medisave has been a positive force in controlling costs. For them, although growth rate in Singapore’s medical expenditures has exceeded growth rate in its GDP since 1984, this can be explained by a general rule that people invest more in health care as they become wealthier. A world-wide study has shown that for every 1 percent of GDP growth, health spending rises 1.43 percent (Murray, et al., 1994). An interesting comparison can be offered by the case of Hong Kong, another prosperous Chinese city-state. For the period 1984-1990, Hong Kong increased health spending by 13.1 percent annually with a GDP growth rate of 6.7 percent per year, while Singapore at the same time, with Medisave, increased medical expenses by 11 percent per year with a GDP growth rate of 8.3 percent annually. This shows that a significantly smaller fraction of the newly created wealth went to new health care expenditures in Singapore than in Hong Kong (Massaro and Wong, 1995, pp. 269-270).

In any case, this issue (whether Singapore’s saving strategy of health care can significantly contain health care costs) is not our primary concern in this chapter.
implemented, its principles are instructive of ideas and values that many Americans hold. These principles are:

(1) Security: Guaranteeing comprehensive benefits to all Americans;
(2) Simplicity: Simplifying the system and cutting red tape;
(3) Savings: Controlling health care costs;
(4) Quality: Making the world’s best care better;
(5) Choice: Preserving and increasing the options you have today;
(6) Responsibility: Making everyone responsible for health care (The White House Domestic Policy Council, 1993, pp. 21-25).\textsuperscript{82}

The principle of security carries a clear sense of universal access to health care, namely, ensuring all Americans health care benefits. This sense is not present in the Singaporean principles. The principle of simplicity wishes to cut off excessive bureaucratic rules and paperwork. The spirit of this principle should be implicit in the Singaporean reform, although the principle is not articulated there. The principle of savings is by no means to suggest the creation of individuals’ saving accounts for their health care as Singapore did. Rather, it simply suggests increasing health care competition on price, bringing together consumers and business in “health alliance” to get good prices on health coverage from

\textsuperscript{82} The Ethics Working Group of the Clinton White House Health Care Task Force was originally asked to articulate a list of principles and values to reflect shared moral traditions underlying health care reform. The group worked out this list: Universal access, comprehensive benefits, choice, equality of care, fair distribution of costs, personal responsibility, intergenerational justice, wise allocation of resources, effectiveness, quality, effective management, professional integrity and responsibility, fair procedures, and local responsibility (The White House Domestic Policy Council, 1993, pp. 11-13). According to Norman Daniels, a leading member of the group, the simplified six principles (security, savings, simplicity, responsibility, choice, and quality) adopted in President Clinton’s report “map only in part the list produced by the Ethics Working Group” (Daniels, 1994a, p. 427). However, insofar as the major argument of this chapter is concerned, differences between the two lists do not really matter.
insurance companies, lowering administrative costs, limiting the rising of health premiums, and criminalizing health care fraud (The White House Domestic Policy Council, p. 23). The principle of quality aims at improving health care quality. The spirit of this principle should also be implicit in the Singaporean reform. The principle of choice preserves patients' freedom in choosing health care plans and providers as they please. This is similarly articulated in the Singaporean principle. Finally, the principle of responsibility conveys a vague sense of “all people's responsibility for all people's health care.” In particular, the explanation of this principle mentions three things. First, the plan “asks drug companies to take responsibility for keeping prices down.” Second, it “discourage[s] frivolous medical malpractice lawsuit” and “limits lawyers' fees.” Finally, it asks everybody “to pay something for health care coverage, even if the contribution is small” (The White House Domestic Policy Council, p. 25). Taken together, this principle pays only “ostensible homage to the role of personal responsibility,” but “does little actually to bring individuals into direct contact with economic consequences of their health and health care decisions” (Morreim, 1994, p. 456). It in fact reflects the sense of government responsibility for intervening in the free market of health care and guaranteeing everyone health service benefits, no matter how little one pays for health care. This principle sharply contrasts with the Singaporean principle of self-accountability and self-reliance for health care for oneself and one's family.

In comparison, it is clear that the American principles emphasize the requirements of universal access, government responsibility, and payment irrelevance. These requirements do not exist in the Singaporean principles. Instead, the Singaporean
principles focus on the values of self-accountability, self-reliance, free market competition, and only *affordable* minimal standards of health care guaranteed by government to those who could not afford to pay. These values are absent in the American principles. Taken together, the American principles indicate a government-responsibility model of health care delivery, while the Singaporean principles manifest a family-accountability model of health care delivery.\(^{83}\)

The Singaporean model regards health care as essentially an obligation of the family. The CPF plan firmly establishes that individuals and families, rather than governments, are responsible for providing for their own social security benefits in general and health care benefits in particular. Every Singaporean is encouraged through the public health education programme to be responsible for their own health care and be made aware of the adverse consequences of harmful habits like smoking, drinking, bad dietary intakes and sedentary lifestyles. All working Singaporeans, including self-employed persons, are required to save for their medical care to avoid reliance on state welfare. As a savings scheme, Medisave provides incentives for members to save and avoid unnecessary use of medical services. If they stay healthy, the Medisave savings remain theirs and they can earn interest from them. One’s Medisave balance will be paid in cash to the account holder’s nominees upon his death, and it will be free from estate duty (Singapore Ministry of Health, 1993a). Singaporeans keep their hospital lengths of

\(^{83}\) I term the Singaporean model of health care delivery a family-accountability model rather than a self-accountability model because it is basically a family-oriented structure. One’s Medisave account covers not only oneself, but also one’s immediate family members, namely, spouse, children, and parents. In other words, under the Singaporean system, one is not only responsible for financing health care for oneself, but is simultaneously responsible for one’s family, too. As will become clear in the next section, the family is inherently important in the Confucian Chinese culture. For a most recent book regarding Confucianism and the family, see Slote and De Vos, 1998.
stay to almost the same level as HMOs in the United States. The difference is that in American managed care systems, administrators make health care decisions for patients, while in Singapore patients make decisions for themselves (Asher, 1993). Nominal out-of-pocket payments exist even in subsidized public immunization clinics. This serves as reminders that health care is never as a free-of-charge good (Massaro and Wong, 1995, p. 271). Finally, unlike tax-based financing, Medisave does not place undue burden on a declining number of employed and the young to support an aging population.

In contrast, the American model reflects the idea that it is government’s responsibility that everyone should gain access to health care without financial barriers. The very first sentence of President Clinton’s letter to Americans in October 1993 begins with this statement: “Every American must have the security of comprehensive health benefits that can never be taken away” (White House Domestic Policy Council, 1993, p. xiii). In the section of “Responsibility” in the President’s Report, Clinton’s following words are quoted: “we need to restore a sense that we’re all in this together and that we all have a responsibility to be a part of solution” (White House Domestic Policy Council, 1993, p. 89). All these words suggest collective or government obligation for universal access to health care, rather than individual or family responsibility for their health and health services. Indeed, this American model of reform has nothing to do with real responsibility on the part of patients, much less families. It does not require patients directly to experience some of the economic impact of their choices. Instead, “it asks them to live healthily and to make a token financial contribution, but perpetuates the myth of free choice by continuing a heavy economic insulation” (Morreim, 1994, p. 466).
IV. Egalitarianism vs. Familism

Daniels claims that the American principles underlying the Clinton health plan (1) "are compatible with central moral and political traditions," (2) are compatible with "rigorous theoretical accounts of justice and health care," but (3) "are 'freestanding' points of agreement, not presupposing any particular theoretical background" (Daniels, 1994a, p. 425). Assertion (3) is evidently false. Although these principles were agreed by members of the Ethics Working Group of the Clinton White House Health Care Task Force in 1993, people have formed substantive disagreements rather than agreements regarding them. Moreover, the failure of the Clinton plan because of the broad objection itself shows that these principles are very unlikely to be "'freestanding' points of agreement" in the United States.

These principles are indeed compatible with Daniels' own account of just health care in following John Rawls' contractarian theory of justice. As Daniels concedes, "most of the principles are derivable from or compatible with my own fair equality of opportunity account of justice in health care" (Daniels, 1994a, pp. 427-428). How rigorous Daniels' account is can be controversial, but his assertion (2) is roughly correct.

Can Daniels' assertion (1) (these principles "are compatible with [American] central moral and political traditions") stand? By "traditions" here Daniels certainly means Western or American traditions. For him, because American health care reform

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84 For a rigorous critique of the Clinton health plan as well as its underlying principles, see a group of essays in a thematic issue [No. 5, Volume 19 (October 1994)] of the Journal of Medicine and Philosophy entitled 'The Ethical Foundations of Health Care Reform: Clinton and Beyond.'
affects the lives of all Americans, the principles and values that guide it must rest on the
moral and political traditions to which the American nation is dedicated (Brock and
Daniels, 1994, p. 1191). There is no doubt more than one central Western or American
moral and political tradition. Among them Daniels should be most willing to pick up the
modern Western liberal tradition represented by, for example, Rawls' two principles of
justice in the contemporary time, since Daniels follows and adapts it to frame a
substantive account of health care justice. This tradition, while clearly cherishing and
protecting individual freedom and civil rights, places a particular emphasis on equality,
especially the equality of opportunity. This egalitarian vein is explicitly expressed in the
Rawlsian principle of fair equality of opportunity. And this egalitarian value, Daniels
announces, is rooted in the history of American constitutional reflections: "Our nation
was founded on the belief that all individuals deserve equal opportunity to pursue their
chosen goals in life" (Brock and Daniels, 1994, p. 1191).85 This statement appears

85 Engelhardt argues that Daniels cannot make this announcement without qualification.
According to Engelhardt, the American Constitution, unlike the constitutions developed
elsewhere in the 19th century, is "a formal-right constitution, not a material-right
constitution." It guarantees equality of opportunity only in the formal process of the law,
but equality of opportunity elsewhere, much less equality of outcome (Engelhardt, 1994a,
p. 505). Moreover, Engelhardt contends that the emphasis of the American constitutional
reflection was not placed on equality. Instead,
[t]he genius of the American constitutional endeavor was its establishment of
limits. The Constitution was to prevent the thoroughgoing enactment in law of
any particular religious, ideological, or moral commitments. The Americans
committed themselves to moderation in virtue and justice, and against the
fanaticism that had often marked the European continent. They recognized that to
pursue wholeheartedly in constitutional law, and in law generally, any particular
understanding of justice, fairness, equality, or moral probity ran the risk of
establishing a tyranny. Essential to understanding the roots of the American
approach to policy-making is its commitment against the establishment of a
national religion or a national ideology. America did not embrace the French
514).
manifestly false, in that the United States was founded as a nation compassing (1) slaveholding states and (2) a people of highly individualistic character, many if not most of whom were ill disposed towards the notion of providing welfare rights out of the common purse. Indeed, many of the reflections on the framing of the American Constitution were directed to creating a polity in which there could be vastly different understandings of human flourishing, as well as substantive safeguards against the development of a welfare state.

Whether it is accurate to assert an American constitutional root for concern about fair equality of opportunity, it has become prominent in the contemporary Western liberalism. In maintaining the importance of individual liberties and political rights, contemporary Western liberalism also cries for government responsibility for keeping equality in society. This has been particularly manifested in arguments for government intervention to maintain equal health care. As Dan Brock and Daniels claim, "[h]ealth care services should reflect only differences in our health care needs, not other individual or group differences" (Brock and Daniels, 1994, p. 1190). Moreover, "everyone must have access to health care services without financial or other barriers" (p. 1189). In short, underlying the American principles that guided the Clinton health plan is a moral perspective that can be termed contemporary Western egalitarian liberalism.

This perspective is certainly not the perspective that guided the Singaporean health care reform in 1984. Rather, it is the basic Confucian understandings and values that shaped the new Singaporean principles for health care.\footnote{The leaders at the time of forming their principles may not have consciously wanted to derive their principles from Confucianism. But their general commitment to Confucian values had already been prominent then.} For one thing, unlike
contemporary Western egalitarian liberalism, Confucianism most cherishes harmony, not equality, in a large society. Although the fundamental Confucian principle of ren (humanity) requires love of every human, it does not require the same type of love for everyone. Rather, it calls one to practice one's love in a clear and definite order, distinction, and differentiation among human individuals. Indeed, Confucians consider some dimensions of human inequality to be morally important. First, human individuals significantly differ from one another in ways in which they possess and exercise the virtues. Some are more sincere, make greater efforts, and thus are practically superior to others regarding the virtues. It is the conviction of Confucianism that those persons should receive more love and respect than others. Moreover, humans are far from being mutually disinterested as Rawls assumes they are in the original position. Instead, they always stand in familial and social relations with each other, relations that are bound to be asymmetrical. Some are born family members. Others are made friends. And still others are remote strangers. Confucianism holds that an appropriate conception of social justice must take such asymmetrical human relations and their moral implications into account. For Confucians, it is wrong to love a stranger as one's family member. It is inappropriate to treat a virtuous person as a common man. In short, the fundamental Confucian principle of ren does not require social equality in the sense that contemporary Western egalitarian liberalism does. Rather, the function of the principle of ren is to bring naturally unequal humans to a harmonious social life.  

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87 For a detailed comparison between Confucian thought and Rawls' liberal theory of justice, see Fan (1997).
perspective contrasts with the Western egalitarian liberal perspective in harmony versus equality.\footnote{The Confucian anti-equality and pro-harmony values are extensively manifested in the Singaporean society. For example, from a recent reflective study of Singaporean politics, we read:}

Moreover, the Confucian tradition takes the family to be a unit autonomous from the rest of society. Confucianism understands the nature of the family as an irresistible arrangement of the Transcendent, Heaven (\textit{tian}), for humans to realize their dynamic potentials of complementary forces, \textit{yin} and \textit{yang}. Hence, every human is born to a family, possesses special relations to other family members, and lives one’s life inseparably from them. Indeed, familial relations are so crucial for Confucianism that they assume three of the five basic human relations that the Confucian tradition emphasizes. It is a Confucian moral requirement that one take oneself as an inseparable

\footnote{The Confucian anti-equality and pro-harmony values are extensively manifested in the Singaporean society. For example, from a recent reflective study of Singaporean politics, we read:}
the overall patriarchalism of the PAP’s [People’s Action Party] state project was confirmed by the increasingly explicit declaration that some people were superior to others. Instances of this elitist sub-text may be found in all major policy areas. A rigorous system of streaming or tracking was introduced in the schools and the growth in the number of higher education places was strictly controlled so that a credentialised elite might be created. Higher quality housing was made available to those who could afford to pay more. Eugenically inspired attempts were made to encourage young people to marry others of a similar level of educational attainment through the setting-up of separate, government-run matchmaking agencies for the holders of ‘0’ levels, ‘A’ levels, and degrees, as well as through encouraging graduate women to have more children. Ministerial virtue was rewarded by raising their salaries to levels to those of the best paid chief executives in the private sector. And, finally, the psychological and material costs of failure were increased by shifting the administration of welfare services to charitable organisations and tightening still further the eligibility criteria for Public Assistance. The latter are now so strict that even many of the ‘deserving poor’, let alone the unemployed, are refused benefit in all but the most desperate of conditions. The summary term with which the existence of this sub-text was officially acknowledged was the same one that was used to summarize the government’s anti-discrimination policy, namely ‘meritocracy’ (Woodiwick, 1998, pp. 227-228).
element of the family, flourishing or suffering with all other elements. Hence, the injury, disease, or disability must be taken as a problem of the entire family, rather than the problem of the individual. Hence, the family must undertake the financial burden of health care for every family member. And medical decisions must be made by the family as a whole.\(^{89}\)

The Singapore health care system reflects the Confucian views of anti-egalitarianism and familism. The Confucian tradition does not require the government to offer universal and equal care to everyone. Rather, it understands health care as the accountability of the family. Like any other goods, health care is never free of cost. The family must save and prepare for the unfortunate occurrence of disease to its members.\(^{90}\)

For Confucians, valuable government intervention takes place only in cases of people who do not have a complete family, such as widows and orphans (see, e.g., Mencius, 1A: 5) or those who suffer from some catastrophic event. This is why Singapore government set up Medishield and Medifund and also set strict rules for application.

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\(^{89}\) For classical Confucian views on the family and familial relations, see Confucius (1971) and Mencius (1970). For a East Asian principle of autonomy that manifests the Confucian family values, see Fan (1997a).

\(^{90}\) One critique of Singapore’s health care system is this: while healthy beneficiaries retain their percent of wage contribution in their health care accounts, less healthy beneficiaries have pay deductibles equal to 5 percent of their wage income before they can use funds from the social risk pool, i.e., Medishield. This arrangement, the critique states, “essentially shifts the responsibility of caring for ill people from the government or employers to workers” and this causes problems of equity (Yip and Hsiao, 1997, p. 250). This is entirely a misunderstanding. Singapore does not take health care as the responsibility of government. Rather, it stresses it as the responsibility of individuals and families.
V. Concluding Remarks

This exploration of Singaporean "Asian values" might be considered as just one of the growing genre of Asian critiques of contemporary Western values, many of which critiques are vague, ambiguous, and problematic. The goal is primarily to indicate by an exploration of a non-Western approach to social justice in health care the substantive role played by moral perspectives in the shaping and justification of health care policy. As the foregoing chapters showed, appeals to moral theories are not enough to account for the full-bodied health policies that many philosophers and bioethicists wish to endorse. As these chapters showed, one could not account for the relationship between theory and policy without attending to the content-contributing role of moral perspectives cum particular exemplars.

91 There are a lot of examples in this regard. Some Asian leaders have tended to emphasize the differences between Western values and those of the various countries of East Asia to contend that the contemporary Western views of human rights and democracy do not suite Asian countries. The critiques are essentially political and are often emotional rather than intellectual. Most critiques have not been placed under careful academic examination. The theme of cultural conflict has also been taken up by some Western observers, most notably Samuel Huntington (1993). Many have also tried to emphasize a list of "Asian values" that are supposed not prominent in the modern West, such as respect for authority, strong families, reverence for education, hard work, frugality, teamwork, a balance between the individual’s interest and those of society, and so on (Hitchcock, 1994). However, to be careful, "Asia" must be spoken in its wide diversity, ranging from the Islam Pakistan to the Confucian Far East. It includes essentially different religious, moral, and cultural traditions and values (Cauquelin, et al., 1998). This work does not intend to undertake any analysis of such "shared Asian Values." Instead, it bases on the notion of "moral perspectives" to examine the substantive differences between Singapore and the United States in their approaches to the proper allocation of health care.
This chapter shows that vitally different moral perspectives underlined the Singapore health care reform and the Clinton health plan. It demonstrates that the moral perspective of the contemporary Western egalitarian liberalism underlying the Clinton health care principles is not recognized and enjoyed outside of the Western cultural context. The moral perspective of the Confucian tradition underlying the Singapore health care principles contrasts with the contemporary liberal perspective in morally important aspects and supports substantively different pattern of health care allocation. The role of moral perspectives may easily be overlooked within the same cultural system such as the Western, because all individuals are assumed to share a similar cultural context in which there seems to be only one general moral perspective in spite of more or less differences from one subculture to another.\textsuperscript{92} Examples from an alien cultural system can play a role of stimulus. It forces one to face differences and find an explanation. While such examples break up the dream of the apparent unity or solidarity in the moral life, they help us recognize the role of full-bodied moral perspective in giving substance to moral accounts.

A moral perspective is most inclusive in interpreting all major matters involved in a domain of moral concerns. They are different from people to people, from community to community. They are implicit in every aspect of moral life, health care included.

\textsuperscript{92} John Rawls' theory of justice provides a prominent example in this regard. Rawls argues that his account of justice is rooted in a "thin" theory of the good and thereby is separated from any full conception of the good life. He contends that his account is compatible with all conflicting but reasonable religious, moral, and cultural doctrines. Only by closely looking at certain particular exemplars shown by Rawls' account (such as its implication for health care allocation as disclosed by Norman Daniels) can we recognize a particular moral perspective giving full moral substance to his account.
From an international view of just health care, we need to go beyond the popular perspective of the contemporary Western egalitarian liberalism, becoming aware of the ever profound diversity and pluralism at the international level. A successful account of justice in health care will thus require more than what can be drawn from theories of justice.
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