Some Remarks on Equality in Health and Health Care

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A title beginning, "Some Remarks on . . ." suggests that the author hasn't figured out how to integrate his or her inspired thoughts into a unified essay. I fear that this generalization is applicable here. In this paper I begin with abstract reflections about how egalitarians should think about inequalities in health and end with concrete remarks concerning the allocation of health care. Along the way, I comment on alternative interpretations of egalitarianism, too.

Health is obviously an extremely important good. Poor health may involve suffering. It diminishes the range of things one can do. It shapes one's relations to others. It may limit one's autonomy and compromise one's claims to a share in decision-making. Health deficiencies are of great moral importance, and there are strong moral reasons to prevent, mitigate, or cure health problems.

Health deficiencies would be of serious moral concern, even if they were equally distributed. But they are not equally distributed, and in a largely healthy population, health *deficiencies* are also health *inequalities*. Curing health deficiencies typically lessens health inequalities. Inequalities in health are stark and consequential, and health care can mitigate them. Does the fact that a health deficiency is also a health inequality provide an additional

[1] Parts of this essay draw on Hausman 2007. I am indebted to David O'Brien for comments on a previous draft.

ground for moral concern and an additional moral reason to provide health care to avoid or lessen the inequality?

Many believe this is the case. For example, Robert Veatch asserts that "justice requires that persons be given an opportunity to have equal health status in so far as is possible" (1981, p. 83) and Anthony Culyer writes, "An equitable health care policy should seek to reduce the inequality in health . . . at every stage of the life-cycle" (2001, p. 281).[2] Does justice require opportunity to enjoy equal health or that health care policy aim to reduce inequality in health? If so, why?

There are two species of egalitarian answers, which do not exclude one another. The first derives from the view that unchosen inequalities in the distribution of good things and bad things across people are morally objectionable. If one sets aside the consequences of individual choices for which individuals are responsible (as I shall throughout this paper), the distributional egalitarian maintains that fairness requires equality across individuals in the overall goods and bads in their lives (Dworkin 1981, Arneson 1989, Cohen 1989, Sen 1992, Temkin 1993, 2003, 2015, Segall 2016). The second species of egalitarianism is concerned with the attitudes individuals have toward one another and the ways in which individuals treat one another. Relational egalitarians aim at a society of equals (Anderson 1999; Scheffler 2003). It is hard to pin down exactly what this means and what implications it has for the distribution of health and health care. There is no reason why egalitarians cannot be concerned both about distribution and about the character of the relations among individuals, and the technical work of economists concerning distribution is by no means irrelevant to relational egalitarians.

[2] See also Peter (2001) and Peter and Evans (2001).

Sections 1 asks what distributional egalitarians ought to say about health inequalities. Section 2 asks the same question with respect to relational egalitarianism. Section 3 turns to health care and addresses the question of what constitutes egalitarian health care. Section 4 sketches an egalitarian variant of cost-effectiveness analysis and points out moral objections to using it to allocate health-care resources. Section 5 considers whether properly regulated markets could operationalize a health-care system that egalitarians could approve of. Section 6 concludes.

1 Distributional egalitarianism and health inequalities

Distributional egalitarians do not maintain that the distribution of everything should be equal. Some inequalities are of no importance. It does not matter whether Helen's feet are wider than Harriet's. Other inequalities, such as inequalities in wealth, are of moral concern because of their consequences. Inequalities in wealth may diminish happiness, undermine democracy, destroy social peace, threaten self-respect, and lead to unfair treatment by the criminal justice system. Distributional egalitarians find inequalities in some overall "currency" to be morally objectionable in themselves, that is regardless of whether they are also objectionable because of their consequences. Different egalitarians have taken the egalitarian currency to be welfare, resources, opportunity for welfare, or capabilities. To simplify the exposition, without taking a stand concerning what the currency of distributional egalitarianism should be, I shall take it to be well-being (whatever exactly that is). Some distributional egalitarians maintain that a moral objection to inequalities in well-being is a fundamental intuition, not subject to or in need of any other justification. Others derive it from the view that justice requires that people get what

they deserve; so equally deserving individuals should be equally well-off. I leave open the question whether distributional inequalities are in themselves *unjust* or whether they are morally bad in some other way.

I have elsewhere criticized distributional egalitarianism. Because there are many plausible competing explanations of the intuitive repugnance many people (including myself) experience when they observe the grotesque inequalities that obtain in the world today among human lives, I question whether those intuitions lend much support to distributional egalitarianism. One can construct hypothetical cases in which only distributional egalitarianism would explain an objection to inequalities, but these cases are unfamiliar, and intuitions concerning them are insecure. Another way to assess distributional egalitarianism is to compare its implications to the implications of relational egalitarianism with respect to some controversial ethical issue, such as the assessment of health inequalities. This essay makes such a comparison, but finds no decisive reason to favor either version of egalitarianism.

Instead of maintaining that the wrongness of inequalities in well-being is a fundamental intuition that has no further justification, one can, like Larry Temkin, base distributional egalitarianism on the view that how well people fare should be proportional to their desert. To hold this view, one must suppose that there is some way to estimate what individuals deserve and (or so I would argue) that one can sensibly hold some agent morally accountable for apportioning reward to desert. I reject these assumptions.

The most obvious way of developing a distributional egalitarian critique specifically of health inequalities is to maintain that it is morally objectionable if, through no fault or choice of their own, some individuals are less healthy than others. This view supposes that health

inequalities imply well-being inequalities. On this view, it is not only tragic that one five-year-old, Mary, comes down with leukemia, but it is unfair or otherwise morally objectionable that she has the disease, while her friend, Ellen, who lives across the street, is in good health. In Larry Temkin's words, "Isn't it unfair for some to be born blind, while others are not? And isn't unfairness bad? These questions, posed rhetorically, express the fundamental claims of non-instrumental egalitarians" (2015, p. 9).

It seems to me implausible to maintain, as Temkin does, that it is *unfair* for some to be born blind while others can see or that a tree limb falls on one hiker, John, and spares his partner, Judy (2003, p. 772). In my view, a state of affairs cannot involve an injustice or any other sort of wrong, unless some morally accountable agent is causally responsible for its initiation or continuation. But there is little profit in arguing the point here, because, regardless of whether one believes that one can sensibly scold nature for its arbitrary depositing of sight or tree limbs, it is only those states of affairs that people can do something about with which policy is concerned.

What then should distributional egalitarians say about inequalities in health? Indeed, what constitutes a relevant health inequality? Health inevitably differs over the course of a life. Compared to adults, infants are severely disabled. Yet it would be absurd to regard inequalities such as these as morally problematic. Moreover, health varies from day to day. Healthy people sometimes get colds. Sometimes, they eat too much and their guts ache. If Mary has a cold today, while Margaret, who was sick yesterday, feels fine, there is nothing for the distributional egalitarian to complain about. Everyone dies, and only a lucky few escape a period of ill-health before dying. What these obvious facts suggest is that the relevant notion of health equality

cannot require equal health at all moments during one's life span. Nor is it (as Denis McKerlie (1989) pointed out) enough for the egalitarian to seek equality in health or well-being over whole lives, regardless of the inequalities among people at various life stages. Another possibility would be to insist on equality of health at each life stage. But such a view places no limits on inequalities in health across life stages.

Although I shall return briefly to these puzzles later when discussing relational egalitarianism, I shall suppose that the distributional egalitarian can avoid specifying what constitutes "equal health", which except as an instantaneous comparison between two individuals at the same life stage, is not well-defined. Distributional egalitarians can instead take health to be equitably distributed when it minimizes inequalities in well-being (ignoring responsibility). Saying this does not, of course, resolve any of the analogous questions about how an egalitarian should want well-being to be distributed over the life course. Instead, this proposal as it were kicks the problems upstairs, where I shall leave them to others to resolve (Galanis and Veneziani 2017; Temkin 1993, ch. 8).

The distributional egalitarian should maintain that health inequalities are *prima facie* policy-relevant moral wrongs only when they constitute or indicate modifiable inequalities in well-being. Health inequalities constitute modifiable inequalities in well-being if and only if they are remediable and uncompensated. I call a health *deficiency* "remediable" when it can be prevented, lessened or eliminated, and I call a health *inequality* remediable only if the relevant

health deficiency is remediable. Leveling down does not count as remediation.[3] Similarly, I stipulate that "compensation" always consists in providing additional benefits for those who have health problems rather than in taking goods away from or otherwise harming those who are fully healthy. Some health deficiencies, such as Tay-Sachs disease, are not compensable. If a health deficiency is remediable and incompensable, then the health inequality constitutes a policy relevant inequality in well-being that the distributional egalitarian should judge to be prima facie morally objectionable.

If a health deficiency is both incompensable and not remediable and expected to remain such, then it is irrelevant to policy, because there is nothing to be done about it. If, on the other hand, it is possible to compensate an individual for an irremediable health deficiency, then whether there is any wrong depends on whether the compensation is forthcoming. For example, despite his paralysis, Franklin Roosevelt was among the better off among his contemporaries, and the egalitarian should see no wrong in the inequality of health between Roosevelt and those with use of their legs.

Although a fully compensable health inequality need not imply any inequality in well-being and thus does not constitute a prima facie policy-relevant wrong, one might argue that compensable health inequalities, even when they are irremediable, may be important to distributional egalitarians as *indicators* of inequalities in well-being. Because poor health is

[3] An egalitarian who accepts leveling down will find all health inequalities to be remediable: simply make everyone else just as unhealthy as those who are least healthy. I shall assume that distributional egalitarians do not endorse such leveling down.

more prevalent among those who are poor, socially excluded, badly educated, insecurely employed, and so forth, health inequalities can serve as indicators of inequalities in well-being.

Of course, egalitarians already have indicators of well-being, such as income, wealth, and consumption. But these indicators are flawed. Although wealth and particularly income are straightforward to measure, they are spread over families, and it is difficult to tell how they are distributed across individuals. Moreover, measures of income and wealth omit non-monetized aspects of consumption. Consumption seems to be more closely connected to well-being than is income or wealth, but consumption may be wasted or harmful. For these reasons, health might seem a promising alternative for the distributional egalitarian. Unlike wealth, income, and consumption, its relevance to well-being is straightforward, and it pertains to individuals rather than families. Moreover, individuals are arguable less responsible for their health than for their income or wealth.

Despite the plausibility of these considerations, I do not think that it is possible to justify an egalitarian concern for health inequalities on the ground that they are useful proxies for the overall inequalities that egalitarians are concerned about. First, indicators should be easy to measure, and health is as difficult to measure as is well-being itself. Indeed, health economists commonly regard measurements of health as measures of an aspect of well-being, which they call “health-related quality of life.” If measurements of health presuppose measurements of well-being, then measurements of health are of no use as indicators of well-being. Even if not thus circular, measuring health raises technical and conceptual problems. Second, health is a problematic proxy for well-being because it is less tightly correlated to other variables bearing on well-being such as education, income, wealth, or social status than are other indicators.

Although those who are poor, uneducated, socially excluded, and of low social status are generally less healthy, nevertheless a substantial minority of those near the bottom of the social hierarchy in affluent countries are fully healthy, while eventually disease and death catch up with even the most privileged. In contrast, among those who are uneducated, socially excluded, and of low social status, will be few who have high incomes.

So-called "specific" egalitarians (Tobin 1970) will find health inequalities of moral concern even if they are, as I have maintained, poor indicators of inequalities in well-being and constitute inequalities in well-being only in special circumstances. Specific egalitarians are concerned about the distribution of the components of welfare as well as the distribution of overall welfare. In their view, it is better if health and other components of well-being are equalized separately than if there are compensating inequalities in the different constituents of well-being. This view is problematic. If it is better to equalize both health and other components of well-being such as friendship, rather than to let inequalities in one good compensate for inequalities in others, why stop there? Why not insist that each of the many dimensions of health, such as mobility, pain, agility, emotional stability, and so forth be equal too? Is it morally objectionable that some people have intense emotional ties to a few while others have superficial friendships with many if they two are equally well off? Although specific egalitarianism may occasionally be of practical value, pointing us to the best way to remedy an overall inequality, it appears to me to have no principled justification.

The intuition that an egalitarian should prefer to remedy health deficiencies rather than to compensate people for them, as the specific egalitarian recommends, reflects, I believe,

doubt that health differences are fully compensable. In the case of severe health problems, such doubts seem reasonable, but differences in health are often fully compensable.

My view is thus that the (univariate) distribution of health within a population is of little moral relevance to egalitarians. I am not of course denying that health and inequalities in health matter. As a central capability, a determinant of opportunity, a cause and constituent of well-being, and sometimes a crucial influence on the character of relations among individuals, health is obviously important, and information about the correlations between health and other important social variables is of great importance in offering an egalitarian appraisal of a society and in designing effective egalitarian policies. While the shape of the distribution of mortality rates across a population tells egalitarians little, the correlation between those rates and variables such as income tells them a great deal. But it is only remediable and uncompensated inequalities in health that can constitute by themselves inequalities in well-being. Only those inequalities are of *prima facie* concern to distributional egalitarian appraisal and policy.

This means that the distributional egalitarian's focus should be on the social determinants of health – or more generally, the correlations between health and other factors – and on health care – that is, the prevention, cure, and mitigation of health deficiencies. Health care is of special importance because of its relevance to remediation.

2 Relational egalitarianism and health inequalities

As I mentioned before, there is a second egalitarian ground for concerns about inequalities, including possibly health inequalities. This species of egalitarianism focuses on the relations

among individuals. The relational egalitarian seeks “a society of equals” (Scheffler 2003). Such a society avoids oppression and relations of domination and subservience. It allows all its members to enjoy robust self-respect, unless they have behaved shamefully. It honors each as a source of legitimate claims and holds each responsible for the contours of his or her own life, except where unforeseen or unaddressable contingencies intervene. In the distribution of benefits and burdens, relational egalitarians insist on impartiality. The members of an egalitarian society respect one another and are concerned about one another.

These comments do not constitute a precise characterization of a society of equals or of what relational egalitarianism implies concerning the distribution of health and health care (which in some cases are surely relevant to how individuals relate to one another). At any moment in time, even in the healthiest population, there will always be many people who cannot be treated as equals. Infants are obviously not the equals of adults, whether or not they can be regarded as equally well-off; and inequalities in the relations between adults and children need not be ethically objectionable. The vision of a society in which at all points in their lives all individuals are able to relate to one another as equals has little relevance to actual human lives, and it would be absurd for the relational egalitarian to condemn every inequality in the distribution of health at a moment in time that hinders egalitarian interactions. A plausible society of equals will apportion its treatment of individuals to their capacities, granting children gradually increasing autonomy, lessening its demands on those who are ill or otherwise incapacitated, while at the same time caring for those who are impaired.

As these comments make evident, the notion of a society of equals is vague and slippery. For example, someone who is unconscious cannot possibly interact with others as

equals. The inequality between those who are conscious and those who are not is stark. Yet, there is nothing morally troubling about the fact that at any given moment, millions or billions of human beings are unconscious, sleeping peacefully. Rather than a comprehensive view of equality among human beings, it seems that the relational egalitarian only has a view of what constitutes equality among competent waking adults. What the relational egalitarian wants of health seems to be on the one hand protecting the universal possession of some specified set of age-specific capabilities by adults over some extended time interval, such as a week or a month, and, on the other hand, the respectful, caring and, where possible, effective treatment of those who lack those capabilities.

The relational egalitarian thus appears to have nothing simple, general, and unambiguous to say about health inequalities. Health deficiencies that exclude individuals from sharing in egalitarian relations to others are especially important to a relational egalitarian, but there is no metric of health inequalities that measures the importance of health deficiencies from a relational egalitarian perspective. What matters is how health states bear on one's ability to interact with others as an equal, not overall health or some measure of the magnitude of health inequalities. Although relational egalitarians are under no obligation to provide a distributional ideal, it is unsettling that they apparently do not offer any way to assess the distribution of health in the population.

Nevertheless, I do not think that this feature of relational egalitarianism is a serious objection to it. As we saw above, health inequalities are often not in themselves of concern to the distributional egalitarian either. I conclude that egalitarians, whether distributional or relational, should focus their attention on health care and how health is correlated with other

determinants of well-being. Although the social determinants of health, or, more generally, the correlations between health and other important social variables bearing on well-being, are of great interest, I shall assume that their treatment can be folded into general questions about just social institutions, and, important as they are, I shall have nothing to say about them in this essay.

I will focus instead on health care. Since many people are fully healthy, distributional egalitarians will favor health care that, subject to resource constraints and opportunity costs, addresses all remediable health deficiencies, and they will favor research aiming to make more health deficiencies remediable. Because some health deficiencies have such a devastating effect on people's abilities to relate to others as equals and treating health deficiencies is such an important embodiment of the way in which individuals treat one another, relational egalitarians will also favor extensive health-care provision.

3 Egalitarian Health Care

I shall separate two questions concerning the provision of health care. The first, which this essay will not discuss, asks how many resources should be devoted to health care rather than to other policies that are important to egalitarians. The second question, which is the concern of the rest of this paper, asks how the health-care budget should be allocated among different health care, public health, and health research activities. One answer to the last question that deserves some scrutiny is that the allocation of health care should depend on the individual health-care purchases by individuals, constrained by their budgets, their health insurance, and subsidies.

Before discussing what egalitarians should say concerning the allocation of health care, it is important to point out peculiarities of health care that distinguish it from other essential goods such as food or housing. First, the provision of health care is fraught with informational asymmetries. Patients may have information that providers do not have. Often, providers know more than patients. Patients and providers frequently know more about their health-care needs than government or private insurers. Regulation is required to make it difficult for individuals to exploit these asymmetries.

Second, health care can be extremely expensive and the need for it is intermittent, often unpredictable and sometimes urgent. For these reasons, efficiency requires that all but the extremely wealthy have health insurance, whether provided by the government or private insurers. Insurance unfortunately brings its own well-known problems, especially moral hazard and adverse selection. Regulation is needed to mitigate these problems. To avoid adverse selection, government must insure everyone, mandate some minimum level of insurance coverage, or establish high risk pools. To limit moral hazard, government or private insurers must specify coverage limits, which obviously result in inequalities. To make health insurance and society's provision of health care ethically tolerable, the minimum level of insurance coverage must be comprehensive.

Distributional and relational egalitarians provide different answers to questions concerning the allocation of health care and health insurance. Once again setting aside concerns about individual responsibility, I shall suppose that distributional egalitarians who also seek to promote well-being favor maximizing some function of the quantity and distribution of well-being. Let V, the egalitarian value of some distribution of health care be a function F of

total well-being, W, and some measure of the dispersion of well-being among individuals, D. V = F(W, D). The egalitarian value V is an increasing function of W and a decreasing function of D. This way of operationalizing distributional egalitarianism makes it vulnerable to criticisms of aggregation like those that have been levied against utilitarianism. Although distributional egalitarians rely on a more complicated function of well-being (or some other egalitarian currency) than do utilitarians, like utilitarians, they are prepared to sacrifice the interests of some individuals in order to maximize the value of this function. The way to achieve a feasible distributional egalitarian optimum may run through the misery of a small number of individuals.

In constrast, the relational egalitarian who also cares about well-being asks which allocations of resources to health care promote equality in the relations among individuals. Which allocation the relational egalitarian favors depends in part on the information that the distributional egalitarian relies on – that is, the expected aggregate well-being that results from a policy coupled with the distribution of that well-being. But the relational egalitarian is also deeply concerned about the respect that alternative health care policies show to individuals and about the impact of health states and health improvements on specific capabilities that bear on the relations among individuals. Health insurance is important as a mark of social concern, even if it is never needed. It is however possible that the most egalitarian feasible relations leave some individuals in misery. Neither distributional nor relational egalitarianism imply constraints on the treatment of individuals, and both varieties of egalitarianism can incorporate other moral principles that do imply such constraints.

Neither the distributional nor the relational egalitarian seeks to equalize health care – whatever that might mean. Providing everyone with exactly the same health care would be

ridiculous, because people's health care needs differ. Men don't need pap smears. Moreover, some people need expensive care, while others do not. While notions of envy free allocations have been fruitful in specifying what might be meant by equality of resources, I doubt that there is any useful notion of an envy-free ex post allocation of health-care, short of one that provides complete health care to everyone. Nor is equality of insurance coverage enough, because, unless everything is covered, equality of insurance coverage implies that some people are treated while others are not.

Consider a simple hypothetical example, which derives from a thought experiment Dan Wikler has discussed. You are the head of a ward in which there are 120 patients, all of whom will be in pain for the next month. Half of the patients are in truly excruciating pain. Their health-related quality of life (HRQoL) is .5 on a scale running from zero (death) to one (full health). The HRQoL of other half of the patients, who are in moderately severe pain is 0.8. However, they are also members of an impoverished minority and, all things considered, worse off than those who are in excruciating pain. One pill improves the HRQoL of any patient in pain by 0.2. One pill thus completely alleviates the pain of those in moderately severe pain. One pill lifts the HRQoL of those with excruciating pain from 0.5 to 0.7, and a second pill raises their HRQoL to 0.9. The patients are identical, apart from the pain levels and the fact that those with moderately severe pain are also desperately poor. You have 120 pills. There is no way to get any more pills.

What should an egalitarian recommend? In the real world, this question would probably be decided by established policies dictating responses to a wide range of situations, but for the purposes of illustration, let us set that consideration aside. The following table depicts the

initial situation and the outcomes of three different policies, which are equally cost-effective. The utility numbers assume that the amount that a pill increases well-being, like the amount that it diminishes pain, is independent of the initial level of pain or well-being, which of course need not be true in general.

Groups	Number	Initial HRQoL, Initial utility	Policy 1 1 pill for all	Policy 2 2 pills for Group 1	Policy 3 Mixed Lottery favoring group 1
1 excruciating pain	60	0.5 h 40 u	0.7 h 60 u	0.9 h 80 u	20@0.9h, 40@0.7h 20@80u, 40@60u
2 moderately severe pain	60	0.8 h, 30 u	1.0 h, 50 u	0.8 h 30 u	40 @1.0h, 20@0.8h 40@*50*u, 20@30u

Policies 2 and 3 bring about the most equal distribution of overall health (as measured by the variance in HRQoL), but policy 2 does nothing for the members of group 2. Policy 3 disrupts the equality that obtains within the separate groups. Focusing on the distribution of well-being, as they should, rather than health, distributional egalitarians should favor policy 1 instead of policy 2 or 3, despite its greater health inequality.

A relational egalitarian would approach the question of how to distribute the 120 pills differently. In a society of equals, it may be possible to argue that the greater suffering of those with the greater pain justifies placing a greater weight on their claims. On the other hand, everyone who is in pain, even if it is only moderately severe, has a significant claim. Although the fact that some of the patients are impoverished is a reason to be concerned about them, it

is questionable whether it is a reason to give them a higher priority with respect to health care. To take poverty into account fails to show equal concern for those who are in pain, and prioritizing alleviating of the pain of those who are impoverished does not address the strains that poverty places on the relations among individuals. Giving all the pills to those who are in excruciating pain ignores the significant need of those who are in moderately severe pain, while giving everyone a single pill ignores the arguably greater claims of those who are in very severe pain. What the relational egalitarian would probably favor would be an arrangement such as policy 3, whereby everyone in severe pain gets one pill and then some chance of a second pill.[4] The resulting distribution of well-being will be less equal than giving one pill to everyone, but the relational egalitarian's concern with whether the claims of all individuals have been given an appropriate weight justifies a concern with the procedures as well as with the outcome.

The distributional egalitarian aims at least implicitly to promote the best compromise between making people better off and distributing welfare equally. Although relational egalitarians cannot ignore the distributional consequences of policies, their focus is instead on treating members of the population as equals.

4 Distributionally sensitive cost-effectiveness and its problems

If distributional egalitarians seek to maximize egalitarian value, V rather than welfare, W (Broome 2002), given a fixed health-care budget, then they should employ a variant of cost-effectiveness analysis. They should employ those policies P whose ratio between cost and

[4] One might also propose a weighted lottery in which members of group 1 are given a greater number of lottery tickets than members of group 2.

effectiveness with respect to increasing V, C(P)/ΔV(P), is smallest. Unfortunately, however, employing cost-effectiveness to guide health-care allocation runs afoul of a variety of moral intuitions that it seems egalitarians should share. For example, many people prefer to provide health benefits to those who experience a more severe impact from a disease (such as members of group 1 above), even if they are not they are not, all things considered, worse off, and political philosophers such as Dan Brock (2003) have defended such preferences. Although no one has been polled on an example exactly like the toy case above, survey evidence suggests that many people would prefer policy 2 on the grounds that it prioritizes helping those who are more severely ill at the moment, even though the other policies provide the same health benefits and lead to a more equal distribution of well-being.

On the other hand, surveys show that many people would object to Policy 2, which gives all the pills to the members of group 1, on the grounds that it gives members of group 2 no chance to benefit. To capture such an intuition, distributional egalitarianism would have to take into account the distribution of chances to benefit as well as the distribution of benefit itself.

Although respondents in these surveys may assume that the patients are otherwise identical so that those who are more severely ill are in fact worse off overall, in general respondents assess severity by focusing exclusively on the current health state, ignoring any other factors (such as the deprivation in this case) that make individuals better or worse off. People treat fairness in the chances of receiving treatment as an independent factor. If there is one kidney and two dying individuals, giving the kidney to either individual results in an unequal state of affairs, but it is nevertheless important that the decision concerning who gets the kidney treats the two individuals as equals. What this means when one of those in need of the

kidney has a much longer life expectancy and fewer other health problems than the other is subject to debate.

A further problem with cost effectiveness, which is not eliminated by making effectiveness responsive to the dispersion of benefits, is that it may be less cost-effective to treat the disabled or even to save their lives of those who are disabled than to take care of those who are otherwise healthy. By allowing those with disabilities to die, the population may have fewer health inequalities and less inequality in well-being as well as greater total well-being. Such discrimination is however morally intolerable. Egalitarians will object that it treats individuals in grossly unequal ways.

In any case, modifying the measure of effectiveness so as to take into account not just how much health care contributes to well-being but also how it affects the dispersion of well-being is not sufficient to capture egalitarian concerns about health care. Even if the concerns about severity and fair chances can be defused, which I am inclined to believe, cost effectiveness must be modified to avoid discriminating against the disabled and others who are disadvantaged and for that reason more expensive to treat or less able to benefit from treatment.

5 Equality, health care, and markets

Given the moral minefield through which allocation via cost-effectiveness must tread, might there not be a case for allowing individuals to make their own choices concerning health care, within a market designed to minimize inequalities in well-being or to promote equality in the relations among individuals? Even if individuals are not allowed to spend their own funds or

wealth is completely equal, markets will never perfectly implement the allocation of health care that a distributional egalitarian would ideally favor, because health care needs and their costs are unequal. But I suggest that a health care market arrangement may get as close to equalizing well-being any other feasible alternative, and it may do at least as well from a relational egalitarian perspective.

Contemporary liberal discussions of rationing via cost-effectiveness have often placed little weight on individual choice, which has no special importance within a distributional egalitarian perspective. Moreover, the brutality of allowing life-saving treatment to be determined by the size of one's bank account coupled with the fact that the world's most successful health systems heavily constrain market forces have made it seem obvious that markets cannot distribute health care in an ethically acceptable way. Because proposals for market-based health care are so often poorly disguised efforts to enrich insurers or providers or to benefit those who are already privileged, many of those of good will have dismissed market-based health care as obviously unjust. The American Health Care Act currently under discussion in Congress exemplifies the way in which markets are invoked to justify harming people and aggravating inequalities.

However, the fact that any system of centralized rationing of health care will be inflexible and will limit the choices of individuals is of moral concern. Decisions concerning whether and how to treat and prevent injury, illness, and other physical and mental conditions are of the utmost importance to individuals (Lomasky 1981, Engelhardt 1997). Moreover, the limitation on individual choice may itself matter to relational egalitarians as inconsistent with the respect that should be shown to everyone.

Because resources are limited and have other valuable uses, individual health-care choices must be limited, but if those limitations are imposed by an impersonal market, they can be more flexible than if imposed by regulation. That flexibility may be a source of anxiety for egalitarians, because it seems likely to issue in unequal outcomes. Yet the flexibility may also be attractive, especially to relational egalitarians. Markets can be an appealing alternative to rationing via cost-effectiveness – but only if they work efficiently and they are structured to accommodate egalitarian concerns, including the concerns the lie behind the severity, fair chances, and discrimination objections sketched above.

An insurance voucher system can guarantee insurance to everyone. Whether that insurance is comprehensive depends the size of the vouchers. If there are sufficient resources, a system relying on insurance vouchers can be as generous and comprehensive as any existing system of universal health care. Since health insurance will not cover everything, both private insurance systems and universal health care will result in situations in which some people who need essential health care receive it and others, whose need is no less, do not. If individuals can choose their own insurance (subject to minimum insurance requirements), a private insurance system will create the possibility that one individual receives treatment, while another whose health condition is *identical* does not.

Is this a reason why an egalitarian should prefer a system in which everyone has the same health insurance and individuals are prohibited from paying privately for additional care? I think not. From an egalitarian perspective, there is nothing worse about treating one person rather than another when their health is identical than treating one person rather than another when their health-care needs are equally pressing.

In a regulated health care market, insurers will make use of cost-effectiveness information in devising their benefit packages in order to meet people's needs and to compete effectively for customers. Although minimizing the occasions upon which they deny care is not an objective of private health insurance companies, it is a likely result of employing cost-effectiveness information to design benefit packages. However, since private insurance companies have no incentive to lessen inequalities in well-being that derive from the allocation of health care, egalitarians must impose regulations on the health insurance market.

Moreover, the moral objections to rationing by cost-effectiveness in terms of severity, fair chances, and discrimination do not disappear, even though they are less pressing in the context of private insurance. The fact that individuals choose their insurance plans weakens the severity objections to not devoting more resources to more serious ailments. "Community rating" (uniform premiums) and guaranteed issue, coupled with proper regulation, greatly diminish concerns about fair chances and discrimination. However, because some resources, such as organs for transplant, are in absolute short supply, some centralized rationing presumably still be necessary.

In a regulated market system, individuals would be able to choose their insurance coverage (beyond the required minimum). Given their insurance and their other resources, individuals choose their treatments, with the advice of health-care providers. People's choices among insurance policies are constrained by minimum coverage regulations and by their budgets, as supplemented by vouchers. Subject to those constraints, individuals choose to purchase additional insurance on the basic of their estimates of what coverage they will need. Their subsequent choices among treatments (which are constrained by their insurance and

their wealth) depend on their estimates of the value of alternative treatments. A market system allows individuals greater freedom to make choices about what insurance they have and what health care they receive, and it is thus more responsive to individual values. It avoids the need for many centralized decisions and the political conflicts that these decisions provoke. Because individuals will choose among insurance plans in the light of their own personal values, the priorities of even a tightly regulated market health insurance system will not match perfectly those distributional egalitarians would favor.

The problems with a private health insurance system, especially adverse selection, are well known, and arguments for the efficiency of markets in general do not carry over to health care. Whether a regulated market system supplemented with insurance vouchers can match the efficiency of centralized systems is controversial.[5]

Rationing, whether by means of the market or by centralized public policy, means depriving people of beneficial health care. It is unavoidable and tragic. The care that individuals cannot get may be needed as urgently as anything human beings ever need. Our compassion calls out to help people who are in desperate circumstances. We hate the institutions that prevent them from being helped. We are outraged when urgently needed health care is denied, whether by a centralized bureaucracy on grounds of cost-effectiveness or by a market system

[5] In 2006, the Netherlands instituted a highly regulated universal health care system that relies entirely on private insurance companies. So far the system is functioning reasonably well, but it is too soon to draw conclusions concerning its efficiency or long-run tenability. See Daley and Gubb (2013). Singapore's health system shows that under special conditions (which may not be reproducible elsewhere) the market can allocate health care extremely efficiently and achieve excellent health outcomes. See Haseltine (2013).

on the grounds that the individual cannot pay for it, and her insurance doesn't cover it.

There are important differences in the two cases. A centralized system is less flexible, and it casts the government in the role of the villain responsible for saying "No." Centralized rationing is thus politically dangerous, and to preserve legitimacy, a centralized universal health-care system may wind up devoting more resources to health than most people would rationally choose. In a market system, although there may be political conflict over the size of health-insurance vouchers and the minimum insurance requirements, the culprits who deny coverage are private insurance companies. Moreover, since individual's coverage, under egalitarian conditions, depend on their own choices, distributional egalitarians may find the resulting inequalities of lesser moral concern. Relational egalitarians will appreciate the ex ante equality, but health inequalities that interfere with egalitarian interactions among individuals will still be of concern. The fact that coverage depends on choice will in any case mitigate complaints about coverage.

On the other hand, the justification for denying treatment in a market system consists in prior insurance choices and individual budget constraints, while in a competent and legitimate centralized system, treatment is withheld in order to use resources to provide greater health benefits for others. Centralized rationing via cost-effectiveness requires and nurtures solidarity and impartial benevolence, which are compatible with egalitarian values, while rationing via markets encourages that view that each person should sink or swim on her own. Neither method avoids all discrimination and conforms perfectly to what egalitarians want. Both demand a readjustment of our moral dispositions.

At the risk of sounding like a republican, I confess that it seems to me that if it can be

made to work, a properly regulated market health-care system linked to generous subsidies that guarantee that everyone has access to comprehensive health insurance can be an attractive egalitarian policy. It addresses most of the ethical quandaries facing the use of cost-effectiveness analysis, and it also allows the flexibility that is vital in making choices that are so important to individuals. On the other hand, a market system also undermines solidarity and offends against our compassion.

6 Conclusion

The univariate distribution of health in a population is of little interest to egalitarians, whether relational or distributional, and the relational egalitarian has a hard time saying anything about how the distribution of health bears on whether individuals can interact as equals. The correlations between health and other factors relevant to well-being is of interest to both kinds of egalitarians, even though the relational egalitarian, unlike the distributional egalitarian, has no ultimate interest in distribution.

What is of particular interest to egalitarians about health are mainly the links between health and other relevant social factors and the distribution of health care, public health programs, and health research. It might be thought that health care resources should be redistributed in the most cost-effective way, measuring effectiveness not by the consequences for total welfare alone, but by the consequences for some measure of egalitarian value. But there are ethical objections to the use of cost-effectiveness information to allocate health-care resources, even with an egalitarian understanding of effectiveness.

It is very difficult to adjudicate among the moral considerations that are relevant to the

allocation of the health-care budge: efficiency with respect to egalitarian objectives, prioritizing the treatment of those whose health problems are worst, offering fair chances to all, and avoiding discrimination are difficult problems. Regulated markets offer one possible approach to these difficulties.

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