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Health Care and Needs for 'Health'.

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My interest is in the application of Rawls' principles of distributive justice to the allocation of health care. In developing an interpretation of those principles I encountered the problem I present below. Although this issue is problematic for Rawlsian theories, it also has implications for any distributive theory that measures the impact of health care distribution via the mechanism of incremental movements in health or its absence.

It is often assumed that the primary task of health care is the restoration and maintenance of health, and that the moral importance of health care largely arises from this connection. Although inequalities exist in the distribution of other goods, the distribution of health care is thought to be special precisely because 'health' itself is in some sense special. How health needs are to be characterized is of central concern to the establishment of such distributive principles.¹ But, a theory of health needs rests upon the assumption that there is, or could be, a general theory of health.² Currently there is no consensus on a general theory of health and it seems increasingly unlikely that such a consensus is possible.

¹ For instance, if we apply the Rawlsian difference principle to the allocation of health care, then we need some mechanism for determining who is worst off under the distribution. Under the difference principle we are required to distribute social resources in such a way that over time, we improve the situation of the least well off. Usually, the 'worst off' have been identified as the sickest

² Recently Bjorn Hofmann, "On the Triad Disease, Illness and Sickness" *Journal of Medicine and Philosophy* 2002, Vol.27. No.6. 651-673, argued that the identification of needs arising from ill-health does not require a general theory of health. However, I do not find his view entirely persuasive. Rather each element of the triad seemed to require its own general theory of health, even though these were apparently different theories. Similarly, it is frequently argued that the notion of health need is too amorphous to be useful. However, while the requirement for a general theory of health is most clear in needs based distributive theories, it is also the underlying assumption operating in other forms of distributive theory particularly those that operate under the matrix of QALY maximization. Quality Adjusted Life Years (QALYs) do not strictly speaking constitute a definition of health, nonetheless the matrix has as its central assumption that the primary function of health care is health benefit maximization and/or reduction in ill-health burden. They inevitably therefore suffer the same difficulty in determining an 'objective' assessment of benefit and burden. Public surveys conducted into attitudes toward such assessments for example, have tended to show that populations do not always share the same values as the developers of QALY systems, i.e., they do not share the same assessment of benefit and burden. See Eric Nord, Jeff Richardson, Andrew Street, Helga Kuhse and Peter Singer. "Maximizing Health Benefits Vs Egalitarianism: An Australian Survey of Health Issues." 1995. *Social Science and Medicine*. Vol.41. No.10. 1429-1437.

In order for a develop a consensus on the issue of what constitutes 'health' it must, at least in principle, be possible to provide a justification for the adoption of a particular view, that does not already presuppose the said view. Unfortunately, attempts to define general theories of 'health' result in precisely this form of circularity.

General theories of health typically fall into one of two categories. They are either 'welfare' or 'functionalist'.³ There are many varieties of welfare models, but the World Health Organization's⁴ definition of health still provides a useful illustration of some of the central problem with such models. You will recall that 'health' according to the WHO is "...a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity."⁵ The idealized condition of complete wellbeing and the concept of 'health' are synonymous. In effect, this makes the problem of 'health' the problem of devising a general theory of well being.

The WHO definition suffers from a problem common to maximizing principles in general. That is, under conditions of limited resources and where we are required to maximize more than one criterion at a time, we will encounter instances where the individual criterion will come into conflict. We are unable, in this instance, to maximize one without reducing some aspect of the others. We could maximize physical well being for example, but only if we had control over the choices that individuals make, thereby reducing their social well-being. Under this definition, our maximum levels of wellbeing are to be very low⁶, or the definitional structure of the concept is itself faulty.⁷

The attempt to maximize individual elements of the definition also encounters the problem of assuming what the theory seeks to establish. Specifically, it is not possible to establish a plausible measure of the condition of 'completeness' without appeal to a preexisting view of 'health'. For instance, if we use the maximum fitness potential of each individual as a measure of complete physical wellbeing, we encounter the problem that the potential of some individuals, individuals with paralysis for instance, is extremely low. Nonetheless, provided such individuals reach their maximum potential we appear committed to the view that they have complete physical wellbeing and are therefore healthy.

If we attempt to measure completeness inter-subjectively, then most people will be unhealthy. The majority of people simply lack the physical capacities of elite athletes. Falling short of such a standard is to fail to reach the inter-subjective potential of human beings and therefore to be less than completely 'healthy'.

³Actually there many different ways in which might characterize the divisions of this debate. They are divided between reductive and non-reductive, and objective and subjective and of course functionalist and welfare. These classes are not precisely overlapping descriptions however, the distinction I nominated here is I believe the most useful.

⁴ Hereafter 'WHO'.

⁵ World Health Organization. Basic Documents. Geneva: World Health Organization. 1966. p.1.

⁶ Daniel Callahan. "The WHO Definition of "Health"." p.92.?

⁷ Fred Feldman. Introductory Ethics. Sydney: Prentice-Hall. 1978. p.27. The difficulties associated with requirements to maximize more than one variable at a time are common to what Feldman refers to as defective formulations of utilitarianism.

Worse, the condition of 'completeness' itself presupposes some ideal, of which it is a condition. In this instance, it presupposes a concept of 'health'. If an individual's physical wellbeing can be improved then they are not completely healthy. However, we have no way of knowing whether or not an individual has reached their maximum potential for physical well being, unless we already have a view of what is possible for this individual or this individual relative to the species. For that, we need some sense of what is possible for the species.

The alternative approach to the measurement of physical wellbeing might suggest that we allow individuals to estimate their own wellbeing from their own perspective.⁸ However, the difficulty with this approach is individuals are inclined to estimate their own wellbeing by reference to expectations that in turn are governed by their current situation.⁹ An individual's subjective view of their own health will tend to reflect their expectations for health. But, expectations for health are governed by such things as the availability of health care. Subjective estimations of wellbeing tend to reflect current distributions, whatever those distributions happen to be.

In other words, the WHO trades upon background assumptions about the concept for which it is supposed to be a general theory. Its' definition of 'health' depends upon our having an already existing view of 'health' that is not contained within the definition itself but without which the definition would be implausible.¹⁰

Functionalist models might nominally be considered the more plausible but in fact fare no better. Most biomedical models of functionalism are to some degree based on the influential work of Christopher Boorse.¹¹ Under Boorse's concept of health the "state of an organism is theoretically healthy, i.e., free from disease, in so far as its mode of functioning conforms to the natural design of that kind of organism".¹² Diseases, including injuries and congenital disabilities, are "deviation[s] from the natural functional organization of the species".¹³

The concepts of 'natural design' and 'natural function' are central and inter-linked in this model. The natural design of an organism or part of an organism is determined by its actual functional role

⁸ Presumably, in order to be plausible this would have to be restricted to rational individuals and the definition of rational might present its own problems.

⁹ We need some sense of the resources that are to be distributed in order to develop any meaningful preferences for such resources. Without knowledge of a resource's existence and some appreciation of the nature of the resource, it is simply impossible to form a meaningful preference for that resource. We cannot develop a preference for X if we do not know what X is and we certainly cannot develop a preference for X if we do not know of its existence. Knowledge of resources comes through acquaintance, even if the acquaintance is only indirect. To a large extent then, our current circumstances govern our conceptual horizons. In the case of conditions of our own wellbeing, our estimations will likewise tend to be constrained by our expectations. See James Griffin. Well-being: Its Meaning, Measurement and Moral Importance. Oxford: Clarendon Press, 1986.

¹⁰ The WHO inclusion of mental and social wellbeing, also straightforwardly entails the assumption of normative values, but I am concerned only with structural problems here.

¹¹ See Christopher Boorse . "On the distinction between disease and illness". In Marshall Cohen, Thomas Nagel and Thomas Scanlon. (eds) Medicine and Moral Philosophy. Princeton: Princeton University Press. 1981. p.49-68. And Christopher Boorse. "Health as a theoretical concept." Philosophy of Science. Vol.44., 1977. p.542-573.

¹² Christopher Boorse. "On the distinction between disease and illness." p.57

¹³ ibid., p.59.

and a "function in a biologist's sense is nothing but a standard causal contribution to a goal actually pursued by the organism."¹⁴

Since a function may causally contribute any number of potential goals, biomedical models depend upon the existence of teleological goals.¹⁵ For instance, among many functions actually performed by the human heart, one such function is the production of sound. The biomedical model does not, however, define the function of the heart as 'producing sound,' although the form and operation of the organ is a standard causal contribution to that end.

Rather, such models typically identify the telos of biological functions as the biological goals of "individual survival and reproduction."¹⁶ Human beings are healthy if their various biological components operate in a manner that is both species typical and consistent with these higher level goals.

This strategy is also intended to dissociate the functional concept of 'natural design' from the "view that an ideal can be simultaneously empirical and normative".¹⁷ The empirical status of an organism's natural design is supposed to tell us nothing about the normative value of such a design, nor of any functioning associated with it. Equally, the teleological goals of an organism are not thought intrinsically desirable. 'Health' under this model is strictly an "instrumental good rather than an intrinsic good"¹⁸ It has value in as much as it enables us to achieve other ends that may or may not be morally desirable but it has no intrinsic value of its own.

Unfortunately biomedical models are subject to a wide range of counter examples that undermine the view that normative value is "completely independent of the meanings of the terms

¹⁴ Christopher Boorse. "On the distinction between disease and illness." p.57.

¹⁵ We cannot for instance simply interpret 'natural' functioning as a statistical average of human functioning. As Boorse himself observes, if we take this approach both too much and too little is included under the concepts of disease and health. If health is a statistical average, then an average life span of forty-eight years was healthy before nineteen hundred, but an absence of tooth decay now is not. Similarly, individuals with type O blood will not be simply unusual but diseased. That these implications are strongly counterintuitive, might in itself be a basis for rejecting the 'statistical average' interpretation of the model. However, a more serious objection is the apparent lack of rationale to statistical averaging.

Statistical averaging takes the mere contingent fact of current statistical averages as the basis for our concept of health but provides us with no obvious reason for doing so. The statistical averages of human biology have changed significantly over time and we presume will continue to do so. A host of variables including average height, weight, life-span, and so on have all altered significantly in the past century, both across the human population and within subgroups of the population. Statistical averaging as an interpretation of 'normal functioning' provides no obvious reason to favor current averages over either past or future averages.

There may of course be 'reasons' for favoring current average life spans for instance, over past averages. However, these 'reasons' arise from views of human wellbeing that are external to and independent of, any view of statistical normality. In other words, although a statistical average is itself value neutral, any reason we may have for favoring one average over another, involves explicit value judgments and this is precisely what Boorse hopes to avoid. Boorse himself concedes that, by itself, statistical averaging is an insufficient basis for a theory of health and an unconvincing interpretation of 'natural' functioning.

¹⁶ Christopher Boorse. "Health as a theoretical concept." p.556.

¹⁷ *ibid.*, p.555.

¹⁸ Christopher Boorse. "On the distinction between disease and illness." p.63.

‘health’ and disease’.”¹⁹ It is simply not the case that all species pursue the goals of survival and reproduction as individuals. Many species have a majority of members who are effectively infertile, and many species pursue reproduction only in a manner that ensures the death of individuals.

Equally, it is not clear that the goal of survival can be gained from observation. All living things age and die. The end state of death is a genuinely universal condition but decline and death are not consistent with the goal of ‘survival’. Under the biomedical form of functionalism this would appear to make all living things, by definition, unhealthy.

Boorse, in his original theory, did not wish to view aging as a disease. Rather he argued that, aging is an "inherent defect of the organism".²⁰ However, if aging is an inherent feature of the functional design of a species, we have no reason to describe it as a "defect" unless we already have a view of the teleological goals that is not supported by observation. If, on the other hand, aging is a "defect" then there is no reason why we should not describe it as a disease.

The presence of counter examples to the functional goals adopted under this model, suggest a choice between potential options, rather than being simply a matter of observation. At least in the case of survival, this choice seems to presuppose a commitment to the functional view of health. That is, we have no reason to prefer survival as a choice of functional goal other than acceptance of the functional model of health.

Non-biomedical forms of functionalism are usually prepared to drop the claim to be non-normative. They argue that although teleological goals, for instance, those of survival and reproduction, constitute a choice between values, such values are in some sense universal. For instance, it might be argued that, other things being equal, people do in fact value survival and reproduction.²¹

Clearly there is no particular goal that all people always value, so devising a structure under which it would be plausible to claim such goals as universal values has proven elusive. It is not clear how we should interpret a condition such as ‘other things being equal’. If increasing infirmity is an inevitable condition of aging, then it is not obvious that people will typically value indefinite survival, even if they suffer from no other constraints. But if infirmity is itself considered a constraint on the value of survival, then our interpretation of the condition ‘other things being equal’ seems to presuppose the value of the goal we choose.²²

¹⁹ Nordenfelt’s version of Boorse’s theory. P.xxix.

²⁰ Christopher Boorse "Health as a theoretical concept." p.566-67.

²¹ Scott De Vito “On the Value-Neutrality of the Concepts of Health and Disease: Unto the Breach Again.” P.543. *Journal of Medicine and Philosophy*. Vol., 25, No. 5. 2000. Pp. 539-567.

²² Equally, it is not clear how we should interpret the view that ‘other things being equal’ post-menopausal woman value reproduction. Indeed, it is doubtful that any woman has ever valued, unqualified, reproduction as distinct from control over reproduction. The notion of ‘reproduction’ *sans* qualification, being valuable as a human goal is ultimately unintelligible.

All teleological definitions of health require a choice of goals, and such goals represent a choice of values relative to our view of the good. The plausibility of such definitions depends upon our inclination to accept the particular version of the good that they presuppose.²³

There are still further non-teleological versions of functionalism that appeal to basic needs as their basis. Under these theories, 'health' is that condition or those functions that allow us to satisfy our basic needs. The problem with all accounts that attempt to define health in this way is that basic needs are themselves typically defined as those conditions essential for health. Strictly, not all general theories of need are functional. But Braybrook's functional theory of needs demonstrates some of the difficulties. He defines need as those things "a deficiency in respect to [which] endangers the normal functioning of the subject of the need, considered as a member of a natural species. In the case of men, such deficiencies might also be said to endanger health and sanity."²⁴

The lack of a general theory of health is a serious problem for distributive theories that rest upon the assumption that such a theory exists. Equally, if the concept of 'health' is essentially expressive of normative values, then a consensus on health needs seems unlikely. People have legitimate disagreements about what is valuable.

This might normally provide a good reason to abandon the notion of needs based distributive theories entirely. However, there is no evidence that alternative types of distributive theory fare any better in the case of health care. Rather the problem seems to be with the initial assumptions. It is in fact not obvious that the primary task of health care is the maintenance and restoration of health, even if we could be sure precisely what that meant.²⁵ Nor is it obvious that the primary value of health care is, or must be, identical with its primary task, assuming we could identify such a task.

On the contrary many of the most serious difficulties in the allocation of health care seem to arise from the assumption that 'health' is the good to be distributed via the mechanism of health care. It is this assumption that gives rise to the 'bottomless pit' problem.²⁶ The excessive consumption of social resources by health care has primarily arisen from the futile attempt to reduce inequalities in 'health' via the mechanism of health care.²⁷ Likewise, what are known as 'leveling problems' also seem to arise from the commitment to distributing 'health' under some or other description.²⁸

²³ Accounts of 'health', that define the concept as 'human flourishing' for instance, presume that we share a particular view of the good.

²⁴ Braybrook. 90-91.

²⁵ Interestingly, many theorists in the sociology or anthropology of medicine do not make this assumption.

²⁶ It is in fact a curious aspect of this debate that it is widely understood that the parameters used to measure public health are only minimally affected by health care systems. But rather than thinking this is a good reason to place less emphasis on the provision of health care, it has become a reason for expanding the concept of health.

²⁷ This is contrary to the view sometimes expressed that it is the focus on 'health care' that gives rise to bottomless pit problems. It will sometimes be argued that in the absence of an agreed version of health need, we are obliged to meet all perceived needs. Thus, society is required to meet all demands placed on health systems. However, the only plausible reason for doing this is if we believe that our obligations to provide health care arise from our obligations to provide for 'health', however that concept is understood.

²⁸ Leveling problems are thought to arise from distributive principles that require us to reduce inequalities in 'health'. It is sometimes argued that under this obligation it is just as permissible to level down as level up. Thus, we

Tentatively, I would suggest that we recognize that health care serves multiple purposes and its importance cannot therefore be reduced to a single value. This might mean that distributive principles should focus on the distribution of health care rather than the impossible task of distributing 'health'.

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may be required to redistribute kidneys from those who have two to those who have none. However, if we are not distributing health, under any description, then this problem does not arise.

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