National Collaborating Centre for Healthy Public Policy

HEALTH IN POLITICAL PHILOSOPHY: WHAT KIND OF A GOOD IS IT?

PRESENTATION SUMMARY

Preliminary version—for discussion

National Collaborating Centres for Public Health
Centres nationaux de collaboration en santé publique

Institut national de santé publique Québec

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FOR HEALTHY PUBLIC POLICY

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SPEAKER

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The National Collaborating Centre for Healthy Public Policy (NCCHPP) seeks to increase the expertise of public health actors across Canada in healthy public policy through the development, sharing and use of knowledge. It is one of six centres funded by the Public Health Agency of Canada located across Canada, each with a mandate for knowledge synthesis, translation and exchange in a different area of public health.

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This is a preliminary document. We invite reader feedback, which can be sent to ncchpp@inspq.qc.ca

FOREWORD

The National Collaborating Centre for Healthy Public Policy (NCCHPP) has a mandate to inform public health actors about the best strategies for improving the health status of the population by promoting healthy public policies. To this end, the NCCHPP develops tools designed to support the analysis of different policy measures and the public policy-influencing practices of public health actors. The Centre's mission includes making knowledge from the social sciences accessible to public health actors, and to this end it has established some partnerships with academic researchers in order to develop our understanding of key concepts and issues.

It is in this spirit that the NCCHPP has developed the Ethics and Healthy Public Policy Project. This project has been pursued in part through a series of activities developed in partnership with researchers associated with the *Centre de recherche en éthique de l'Université de Montréal-CRÉUM* (Research Centre on Ethics, University of Montréal). The goal of these activities was to make explicit or to clarify for public health actors some of the substantive ethical and/or normative concepts in public policies. Another goal was to provide conceptual frameworks to complete those currently used to analyze public policies.

As an introduction to this theme, we offer a summary of a presentation by philosopher Daniel Weinstock. The goal of this presentation was to map out some of the key issues in current research on distributive justice as they may be relevant to individuals promoting public policies favorable to **equitable** health, or targeting equity.

What follows has been transcribed directly from a recording of Professor Weinstock's presentation entitled "Health in Political Philosophy: What Kind of a Good Is It?" This presentation was a joint initiative of the NCCHPP, the *CRÉUM* and the *Département de médecine sociale et préventive de l'Université de Montréal* (University of Montréal's Department of Social and Preventive Medecine). It was hosted by the *Direction de la santé publique de Montréal* (Montreal's Public Health Department) on October 17, 2007. We have adapted the transcription from its original format to enhance clarity for the reader.

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1 DISTRIBUTIVE JUSTICE IN HEALTH: A WORLD OF UNCERTAINTIES

My objective today is to try to provide a framework that may or may not serve as a general analytical framework for addressing the issue of distributive justice in health. Above all, I intend to present part of how health – a concern for equity in health – has become part of the general debate on distributive justice.

Many articles have been published on the best way to organize, for the purposes of equity, the distribution of a society's resources. Until very recently there has been a focus on things such as resources or wellbeing in a very general way, without specifying an institutional framework such as health. For some time, distributive justice theorists have been specifically interested in health, and I would like to speak briefly about where we are in this debate. I will not be reaching any real conclusions, meaning that much work remains to be done in this area and that there is much indecision over the best way to integrate health into debates on distributive justice.

The interest in distributive justice in the area of health is coming from two different directions. Distributive justice theorists became interested in health for obvious reasons: the crises in health systems around the world, and the feeling that our health resources are increasingly out of synch with our need for services—and that therefore, we need to pay more attention to the specific issue of equity and justice in health.

There is also convergence on this issue in the philosophy of health, in traditional bioethics. It is becoming progressively clearer that to focus uniquely on the traditional subjects of ethics in health – clinical ethics and research ethics –leads us that ignores how research and clinical activities exist in a larger context of resource allocation, one which often determines the available choices, either in research or clinical pursuits. If we focus on subjects as narrow as research and clinical concerns, we risk missing a significant part of what needs our attention from a normative point of view.

So there is some kind of convergence on this nascent interest in distributive justice in health and it is coming from at least two directions: from theorists examining traditional distributive justice, and from actors in bioethics. There has been a great deal of philosophical interest in this issue over the last 10 or 15 years, but there remains much uncertainty, much indecision as to how health should be integrated into the debate on distributive justice. This uncertainty or indecision is in some ways tied to three distinct uncertainties, which tend to combine.

1.1 UNCERTAINTY OVER THE OBJECT: WHAT IS HEALTH?

First and foremost, there is uncertainty over what we are talking about when we speak of health. What is this object that we would want to subject to a just distribution? What are we talking about? Clearly there is a whole spectrum of potential responses, from a narrow physical or biophysical view of health, to the World Health Organization's notion that health involves not only the individual's physical health but also their environment, their place in the social environment, as well as their psychic or mental health. There is therefore a broad range of

possibilities, from the very narrow – the strict biophysical notion of health, morbidity, etc. – to something much more open, much more multidimensional, and everything in between.

So the first area of indecision is indecision over the object of the discussion.

1.2 UNCERTAINTY OVER THE GOAL OF DISTRIBUTIVE JUSTICE IN HEALTH

There is also uncertainty over what should be the goal of distributive justice in health. For example, one could think that if we examine health as the object of equity, we want to ensure that individual health status is distributed as equitably, as fairly, even as equally as possible. But it is not clear that this is the best approach to the debate on distributive justice in health. There is a strong trend in the literature that consists of saying that what should be the objective of a theory of distributive justice in health is not so much the health status of individuals *per se*, but rather the determinants of health, the opportunities for health. All that contributes to individuals being able to lead healthy lives; these are the things that we should be trying to distribute fairly, or equitably.

So the second area of indecision is indecision over the goal we are targeting, the objective. Clearly the goal is to improve the health of the population, but what will be the means? Are we going to be directly concerned with people's health and say that we need to equalize the health status of individuals or make health status more equitable? Or rather, should we identify the main determinants of health, those that are clearly under human control, which may be affected by human action? This opens a very wide spectrum, from genetics, of course, to the social determinants of health. What should we do? Which of these objectives should we adopt? They are not entirely independent since, of course, if we adopt a broad definition of health, the resulting social, economic, and other determinants of health also become broader. The broader our conception of health is, the greater the collection of social, economic and other factors affecting individuals' health status will be. These two objectives represent real alternatives for a theory of justice, but they are also conceptually intertwined. A conceptual decision on the first dictates a more or less wide opening to the second and, therefore, to the issue of the determinants of health.

So consider the two uncertainties that I mentioned at the outset. First, at the most fundamental level, what are we talking about when we speak of health? And second, should we choose – here I am making the distinction in practical terms – should we choose direct or indirect strategies in our attempts to organize health in a just way? Adopting a direct strategy would be to make health itself our main concern, while an indirect strategy would make health resources, opportunities and determinants the main object of concern and, hence, of distribution.

1.3 UNCERTAINTIES TIED TO WHETHER OR NOT THERE IS A THEORY OF DISTRIBUTIVE JUSTICE FOR HEALTH

The third uncertainty is an issue in which I have been absorbed, and one that I have still not been able to resolve in my own mind. As you will see, the more we think about health, the more we come to believe that health is not only biophysical health, but something much broader that includes at least the physical health of individuals (but perhaps also their social functioning, as it is understood by WHO), and the more we tend to add factors as social determinants of health,

the more we can ask the question and therefore arrive at the third uncertainty: does a theory of distributive justice in health truly exist, one that does not simply boil down to a theory of distributive justice, period?

I will try to express this more simply. In order for health, or the determinants of health, to constitute a distinct, non reducible object for a theory of distributive justice, we need to be able to answer “no” to the following question. Imagine an ideal society in which all resources have been distributed fairly and equitably according to your preferred theory of justice or equity. Can we imagine that in such an ideal state, any enduring health inequalities could still be subject to injustice? It is a long question, with many clauses. So you need to imagine a society that is perfectly just, one that is just under an abstract view of justice that does not strictly refer to health. Is it possible to imagine that, within such an ideal society, any remaining inequalities in health – since some would necessarily exist – could nevertheless result from unresolved injustices specific to health? Or would they be inequalities not founded in injustice? In order for health or the determinants of health to constitute a distinct, un-reducible object for theories of distributive justice, the answer to this question needs to be “no”. Even if we equalize or “equitabilize” society to the extreme, using the criteria that have traditionally been applied by distributive justice theorists, there may still be health inequalities that reflect injustices, since health is in some way an independent domain, within which issues of justice are not entirely settled by the justice that exists in the surrounding society.

Such is the third point of indecision: does a theory of distributive justice in health have its own object? If we examine the first two uncertainties and decide to adopt a very broad definition of health and, at the same time, a correspondingly broad notion of the determinants of health on which a theory of justice needs to act, we may answer the third uncertainty in the negative. So there is no distinct object for a theory of distributive justice in health. A society that is just in health is simply a just society, period.

So there you have it, I have in a way laid out the plan of my address, and, to a certain point, I have described some my theoretical concerns in terms of what I perceive to be the philosophical work that lies ahead. What I would like to do now is develop why I believe that we have come to this conclusion.

2 HEALTH STATUS AS THE OBJECT OF EGALITARIAN CONCERNS

I said before that one of the two alternatives for the second uncertainty is to target health as an object of equitable distribution. As a demonstration, let us examine what obstacles must be faced by those who would say that it is the health status of individuals rather than the social determinants of health that should be the direct object of a theory of distributive justice.

There is a parallel here with the line that separates distributive justice theorists – between those known as welfare egalitarians, who believe that welfare should be the object of egalitarian concerns – from those who, in contrast, believe that the object should be the resources people have for securing their welfare. Those who would say that we should choose health status as the object of distribution (the direct strategy) resemble the **welfarists** in the debates on distributive justice taken in its broadest sense. They say that justice should target welfare outcomes rather than resources, which they see as the means to achieving this outcome. So in this debate we should target health rather than the means to attaining such health, which would be the social determinants of health.

So in my mind it is clear that equality in health is itself an objective that is open to many objections. Egalitarianism in a general sense and, in particular, egalitarianism in health, is open to an objection known in the literature as the lowest common denominator objection. Given two persons who are not equal, there are two ways to attain equality; we can lift the first person up or bring the second one down. One may reach the conclusion that in some areas, such as money, there may be an argument for going to the lowest common denominator. In health, it strikes me as completely ludicrous to think that we should equalize peoples' health status at any cost, even if this means going to the lowest common denominator. Clearly the core concern of those interested in attaining justice in health is something that, in the literature is associated with either "prioritarism", or giving priority to the needs of the less fortunate, or the **sufficiency criterion**, according to which we need to ensure (as much as possible) that every individual in society reaches an appropriate threshold of health, and that until such a threshold is attained by all members of society, no other public policy objective in this area should receive greater priority. So having all members of society attain a minimally acceptable sufficiency health threshold becomes an absolute priority. In the case of health, something like the sufficiency criterion becomes the most plausible objective under egalitarian theory.

2.1 THE OBJECTION OF THE TYRANNY OF EXPENSIVE TASTES

Those who are familiar with the philosophical literature on distributive justice will know the classic objections to **welfarist** theories. There is something in the debates on distributive justice called **the argument of the tyranny of expensive tastes.** What exactly is the argument of the tyranny of expensive tastes? Let us consider a context more general than health. Imagine that the objective of the theory is to ensure that everyone enjoys an appropriate level of wellbeing. It is to be expected that the measures taken to produce this wellbeing will not be equally distributed in society. There are people for whom having bread and water is sufficient in order to attain a high level of wellbeing. Others, who are by their very nature more demanding, will not attain the same level of wellbeing unless they can eat *foie gras* and drink superb wines every

day. A purely **welfarist** theory would say that there are fundamental arguments in favour of a redistribution of resources from the first person, who has modest tastes, to the second, who has more expensive tastes. This leads to the objection of the tyranny of expensive tastes. The example may appear ludicrous and the pure invention of a philosopher, but when applied to health, it opens a debate that is now being taken very seriously by health theorists, one related to one's personal responsibility for one's own health status.

What would be the equivalent of the person with expensive tastes in health? It is clearly the person whose dispositions, personal traits and, at the limit, personal decisions do not leave them inclined to make choices and adopt behaviours that are likely to maintain their health. In health, the person who is satisfied with bread and water would be the person whose dispositions, personal traits and personal decisions leave them inclined to make choices that are likely to maintain their health. A theory that targets health status as the objet of equalization would say that there are arguments for redirecting resources from the second person to the first. According to a vision that would make health the goal of theories of justice, the person with expensive tastes in health would have a kind of claim against the other. This result seems counter-intuitive.

To generalize a bit, the objection that can be made against a consequentialist theory, at least in the sense that it would be directly aimed at "equitabilizing" health status, would be to say that these types of theories would be concerned with the distribution of health status in a society, and would be aimed at having this distribution meet certain criteria, including the **sufficiency criterion**, with no concern for the processes leading to a given distribution. Here we are speaking of social processes, but also decision-making processes. Its defenders or those opposed to the consequentialist theory will say that a complete theory of justice should not simply be fetishist about the distributions that are made, as if they simply fell from heaven, but should also show concern for the processes, the social and personal mechanisms that have led to one or another existing distribution of health status in a society.

So the first objection to a direct strategy of distributive justice in health, in line with the classical objections to the theories of distributive justice, is therefore the objection of expensive tastes.

2.2 THE OBJECTION OF THE BOTTOMLESS PIT

The second objection is the argument of the bottomless pit. As we all know, health needs are virtually unlimited. If we were to make this our primary concern of distributive justice there is a real risk that we would completely deplete our social resources, meeting individuals' health needs without addressing other public policy objectives in education, housing, etc. The opponents of **welfarist** strategies have a general concern about direct health policy strategies, stating that it is essential to look beyond health, to examine not only how the resources allocated to health can be distributed more fairly, but also how to arrive at a sensible distribution of resources between health and other public policy objectives, not giving in to this objection. It seems to me that this is an objection that is easy to recognize in our public debates on health.

I believe that these two objections, the objection of expensive tastes and the objection of the bottomless pit, apply independently of our view of health. Even through the lens of a narrow and restricted view of health that speaks of the biophysical health of individuals and ignores their

psychic health, social health, their skills in society, etc., these two objections – the objection of expensive tastes and the objection of the bottomless pit – remain valid.

2.3 THE PATERNALISM OBJECTION

There is a third objection that arises when our view of health is broadened to include the psychic and social dimensions of health: the paternalism objection. In the literature on the first uncertainty – What is health? – we find proposals for a slightly objective and rigorous definition, even if only for biophysical health. These proposals are decisively open to important objections. Perhaps you are familiar with the proposal made by Norman Daniels, one of the main philosophers in health, health ethics, and the political philosophy of health, which says: "Listen, health is biophysical health. It is something like normal functioning, what is normal functioning for the species." So to say that a human being is healthy is to say that they can function as a normal member of their species and that there is something like normal functioning that should be everyone's goal. For example, this type of definition is used in debates on genetics to try to establish a clear boundary between what in genetic interventions corresponds to the curative, and is therefore acceptable, and what in genetics corresponds to an improvement, or eugenism, and is therefore wrong. There is no need to dig very deep and apply considerable philosophical pressure on this concept of species normality to understand that it presupposes answers to the following question: "Which health interventions are morally legitimate and which are not?" For example, take life expectancy. The life expectancy of human beings has changed enormously over the last century as a result of two discoveries in particular. The first is vaccination and the second is antibiotics. These two phenomena alone explain why in the 20th century, human life expectancy – at least in wealthy nations – rose more than in any other period of history.

Is it possible to say with scientific certainty that what vaccination and penicillin do but what genetic interventions cannot do is re-establish what is normal functioning for the species? I think not. There is nothing abnormal about people dying from what they died from before vaccinations and antibiotics. Clearly technologies redefine normality as they arrive, one after the other. To say that one technology is alright, inasmuch as it re-establishes or establishes normality and another is not because it allows us to go beyond a normality that is in fact a sort of fiction, is quite clearly to make a value judgment on therapies that reset this normality threshold.

It therefore appears that even with respect to purely biophysical health, we have great difficulty arriving at a view of health that would be consensual or **objective** and that does not lead to value-based views that are open to debate. This is especially true when we adopt a conception of health that begins to integrate not only biophysical dimensions, but also social and psychic dimensions, so I see the introduction of values into our conception of health as inevitable. This is not in itself wrong, but it may become wrong if we give these values the status of goals, of objective data, of objective views – scientifically determined – of what health is. Saying what we have in a view of health – it is not a group of values, but rather something scientific – is to risk exercising a form of paternalism that is all the more dangerous if it operates without individuals being aware of it. Once we think that we have acquired an objective view of health, one that carries no values, and we build public policy around it, saying "We're doing this for people's good," rather than using an evaluative framework that can be discussed by the individuals to whom it applies, we have a case of paternalism that will be as difficult to root out as it is unacknowledged.

In summary, I told you that one of the uncertainties concerned the degree to which we need to adopt health itself as an object of moral concern when evaluating a theory of distributive justice in health. Or, should we venture somehow into the determinants of health, health resources, and opportunities for health? I first spoke of strategy, or the first branch of the alternative: what would happen if we chose a direct strategy? Promoting health, or health equity? And I identified certain objections that, once again, are also found in more abstract and general debates on distributive justice. Welfarism, or direct consideration of people's health, may well have these three faults, at a minimum.

3 SOCIAL DETERMINANTS AND DISTRIBUTIVE JUSTICE IN HEALTH

Much as they do in more general debates on distributive justice, these three objections tend to push us toward an alternative theory of distributive justice in health, one that would not directly target health status but, rather, more indirectly target resources, the social determinants of health. The first objection serves to remind us that the direct strategy tends to imagine the distribution of health status in a society as raw data that we need to try to match to a scheme or criterion such as sufficiency, etc., without concern for equity or injustice in the processes that led to these distributions. According to the people who support the determinants of health argument, what we need to do is examine the processes that led to the creation of a given distribution of health status in society and, in particular, ask the question: “Is a given distribution of health status in a society the result of, for example, inequalities stemming from resources, or is it the result of personal decisions for which individuals, at least on the basis of an initial examination, should assume their responsibility?”

It is therefore possible to imagine a distribution of resources that is completely equitable but that, due to the personal choices of individuals, creates enormous health injustices. What we need to examine is their origins, the processes arising from this point of departure that have led to distributions of health status. We therefore need to look at the resources people start out with, and the personal choices they make within the framework of resource distribution. The objection of the bottomless pit leads us to conclude that we cannot simply ask: “What would be an equitable distribution of health resources?” We need to ask another question first: “What share of a society’s total resources must be allocated to pursuing the goal that is health, given the other, legitimate goals of public policy: education, housing, infrastructure, security, etc.?”

So, in a way, the bottomless pit objection tells us that we need to have an ethical debate over how much of the pie we are going to assign to the task of health, and the objection of expensive tastes reminds us that we need a theory on how to distribute shares of the pie. Rather than asking if, given a distribution of shares in the pie, “Is this just or not?”, we should be asking how we have arrived at this distribution, and whether we feel that these processes are just or need to be changed.

3.1 DWORKIN’S THEORY: AN IDEALIZED CONTEXT FOR DECISION MAKING

Several years ago a very important philosopher, Ronald Dworkin, was speaking at McGill and made a very important suggestion. He said: “Listen, we can, in a very elegant way, solve these two problems (how much? how?) using a thought experiment that, without giving us detailed answers, will at least provide a type of framework for thought.” In a text that was reproduced in his book *Sovereign Virtue* he says, “Imagine a sort of thought experiment in which we say to individuals: ‘You are responsible for deciding the total quantity of resources to be assigned to health in a society and, at the same time, the extent to which individuals within the society will be insured against bad luck, sometimes against problems resulting from their own decisions on their health. And you will do this in an idealized situation.” Those of you who are familiar with the debates on distributive justice will recognize a sort of local variant of a position originally taken by John Rawls. You are going to do this under conditions that are idealized in three ways. First,

we will assume that this decision is being taken in a context of a prior, equitable distribution of resources. You therefore need to imagine a social state in which all inequalities in terms of monetary resources, etc. have been settled. Second, it is assumed that you have enough cutting-edge knowledge of all the scientific data you will need in order to arrive at conclusions on the best way to invest in health resources. Third, it is assumed that you are completely unaware of your own personal vulnerabilities with respect to any illness or health problem. So you are making the decision from behind a limited veil of ignorance, such that you will not be tempted to invest disproportionate amounts of resources in any specific health problem that affects you or your loved ones.

In this idealized situation, Dworkin says: “The decisions made by individuals reflecting on what share of the total pie will be allocated to health and on decisions concerning how to distribute these shares will, in and of themselves, be just.” This is because the main factors of injustice, the processes that tend to lead to a given health status, and the distributions of health status that are unjust tend to result from injustice in terms of the initial distribution of resources, scientific errors or imperfect scientific knowledge, or even the natural partiality of individuals. Remove these three procedural factors of injustice, in an idealized situation, and you have a kind of contractualist position that will distribute resources at the macro level: how are we to allocate societal resources to health as compared to other public policy goals such as education or infrastructure? You will therefore have an answer to the issue of macro allocations, and you will have an answer to the procedural question, such as how to go about equitably organizing insurance in a society – health insurance – that will be just because it will be sheltered from everything that tends to introduce injustice into the distribution of health status in the actual societies we live in.

With Dworkin we have a version of the form that could be taken by a “resourcist” rather than a rather indirect or direct theory of equity in health. I will not enter into a detailed discussion of Dworkin’s theory, but I would simply like to point out something that leads to the last of the uncertainties that I mentioned when I began. This uncertainty consists in knowing whether distributive justice in health would not simply amount to distributive justice, period.

Dworkin thinks that one of the great virtues of his theory is that it closes the discussion on something that he sees as a flaw in earlier approaches to thinking about justice in health, what he calls **the hypothesis of health’s isolation from other aspects of public policy**. He says: “The theorists who wrote before me tended to proceed as if health exists in a sort of sublime isolation.” We can think about health needs without making difficult choices that, for example, will make you realize that with a limited pie of social resources, one cannot meet all health needs, that some needs must be abandoned for other public policy goals, such as those already mentioned. According to Dworkin, his theory has the distinct advantage of putting an end to this isolation, since in some way it commits our policymakers to deciding how many resources to allocate to health, given that it will also be necessary to allocate resources to other public policy goals. What I would like to point out here is that if Dworkin’s theory effectively ends one form of health’s isolation from the other purposes of public policy, it also leads to another, which consists of believing that something like a group of easily determinable resources exists: the resources needed for health. These resources would be health care: an easily identifiable set of acts, resources, and things. It would be hospitals, clinics, medication, interventions, etc. And when we speak of knowing the quantity of resources that need to be set aside for health in a

society and how, within a society, we need to ensure that we have access to these resources, we know what we are talking about: this limited set of acts, objects, and institutions known as health care.

Norman Daniels has published a revised and corrected version of his first book on equity in health, *Just Health Care.* In this new edition entitled *Just Health*, Daniels makes one major change to his theory. In doing so, he is followed by many other eminent health philosophers. The change consists of saying, “Listen, I made a mistake in my initial formulation of my theory by fetishizing health care.” When we look at the most compelling studies on determinants of health, we realize that the share that health care contributes to society (narrowly conceived as health outcomes) is infinitesimal when compared to the other determinants of health: education, housing, environment, etc. And that a theory on the equitable distribution of health resources must therefore remove the simplifying assumption that we find in Dworkin’s work, which consists of saying that when we speak of distributive justice and health resources, we know exactly what we are talking about. That we have an object, or a relatively limited set of objects, of which we can say: “This is how they must be distributed in order to achieve equity.” Remove this hypothesis, and we find ourselves with problems of another order. We arrive at the conclusion that somehow everything is health. A moment ago I said that, in the way he organizes thought on distributive justice in health, Dworkin saw the advantage of ending health’s isolation with respect to the other public policy outcomes. But difficult choices need to be made in a society: how are we to make allocations to health, to the environment, to education? If you add to your thinking about health the idea that education, housing, the environment and – why not – security and infrastructure are determinants of health, you have lost what Dworkin considered the first virtue of his proposition, the ability to make a significantly clear distinction between areas of public policy such that choices can be made between them.

4 CONCLUSION

Given these issues, I arrive at the following, somewhat problematic conclusion. Clearly the simplest solution for a theory of distributive justice would have involved an affirmative answer to the first alternative I presented. There is something relatively clear that is called health, and our aim is simply to do what is required so that everyone is able to have a sufficient amount of health – this relatively clear thing. We will measure. I believe that some still maintain this hope, the theories that try to quantify health. We will tell ourselves that we will be able to count: the threshold that everyone needs to attain is 12. And we will be able to go out into society and ensure that everyone has reached 12.

The promise of quantitative theories becomes increasingly difficult to sustain as you broaden your vision of health. We can talk about quantifying biophysical health. Integrating evaluative judgments such as social health and social functioning becomes much more problematic. It would have been simpler to answer "yes" at the first branch in our alternatives. We have a relatively clear object that can be used to determine whether or not each individual in society has attained a threshold. Once everyone attains the threshold, equity is achieved and we move on to something else. The problem is that, for the reasons I have discussed, this strikes me as a strategy that is difficult to justify philosophically. We are dependent on a vision that sees resources or opportunities for health as a more valid goal for a theory of distributive justice. We look at a strategy like Dworkin's and realize that this approach in fact tends to erase the distinction between a theory of distributive justice with health as its object and a theory of distributive justice that does not distinguish *a priori* between health and other objectives.

In closing, I would like to restate my first two uncertainties. The basic problem (and I will conclude with this point) is that there is very strong philosophical pressure to make us choose a vision that is at least partially open, substantially broader than those that would simply target biophysical health. Then, the second uncertainty is: What are the social determinants of health? If we could have answered: "They are this very limited thing that corresponds to health care as defined by our health institutions," we would have had a chance to reach a relatively clear conclusion. We have relatively identifiable resources that we can distribute equitably. But when we have to choose not only a broad vision of health, but also a broad vision of the determinants of health, this is where, all of a sudden, hope – which was my point of departure, knowing that we could arrive at a theory of distributive justice specifically for health – begins to slip away. And it appears that we are thrown back to a point that is even beyond where we started, which in a way is to say: perhaps the most important philosophical work is simply that of determining which principles should govern the institutions of a just society, and abandon any hope of thinking that there can be something like a theory specifically for distributive justice in health.