
Health in the Name of Justice

Does justice require a
right to health?

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I. Introduction

Upholding and seeking justice in society has been important for philosophers and religious thinkers throughout the ages. Debates of different conceptions of justice have ranged from Plato's conception of the just individual, to Aristotle's just community where individuals receive what is owed to them according to their merit, to Kant's claim that justice concerns the "... exercise of will among people; and it is concerned with the possibility and freedom of the exercise of will ..." (Hudson, 2003, p. 11). Interpretations of justice and the value of justice in society vary. Fundamentally, however, theories of justice are concerned with answering the question, what do we as a society owe each other by determining the set of rights that are inalienable and vital for a just society to protect. Theories of justice hope to inform us of the rights that are essential for society to defend and uphold.

The ever increasing amount of medical knowledge and sophisticated medical treatments now available raise questions of social justice in health and has prompted many to argue whether or not there is a right to health. As Charles Fried (1976) explained over thirty years ago, extending certain medical treatments to the poor seemed possible and inevitable during a period when certain medical advances in treating illness and disease, such as the introduction of antibiotics and vaccines, made a huge difference to the health of the population. He claims that in this " 'Golden Age' we could unambiguously afford a notion of a general right to medical care because there were a number of clear successes available to medicine, and these successes were not unduly costly" (p. 29-30). However, as Fried recognised in the 1970s, and is even truer today with the costs associated with chronic illnesses, extending universal medical care to all in society in cases where treatment is expensive and marginally beneficial is problematic at best.

Over the last few decades, societies all over the world have grappled with the struggle to provide equitable, efficient, and quality services on very tight budgets for a vast amount of people and health problems. Causing particular strain on health care services is the ever increasing burden of chronic illnesses. According to a New Zealand Ministry of Health 2009 report, "Two in every three New Zealand adults have been diagnosed with at least one long-term condition and long-term conditions are the leading driver of health inequalities. The predominance of modifiable risk factors such as physical inactivity, obesity and tobacco consumption have continued to fuel the rise of long-term conditions" (2009, p. vii). We can see from this report as well as a multitude of other reports that we have come to a unique position in history, where the provision of a service in order to care for the wellbeing of a society and satisfy popular notions of social justice is being compromised by the private lives of the individuals that the service is designed for. This is because personal lifestyle

choices that are health damaging are costly to treat, and there is a high prevalence of these costs that the availability of health services in general is becoming rapidly unsustainable. As one study of preventable causes of death in the United States found, “Smoking and high blood pressure, which both have effective interventions, are responsible for the largest number of deaths in the United States.” In one sense this is a reason to be optimistic, as it is clear that a number of causes of needless deaths can change. We are able through our lifestyle choices to change our future health and that of our families for the better. On the other hand, this gives rise to a sense of uneasiness when there are calls from some clinicians and advocacy groups for politicians to intervene. In order to preserve and improve health systems, governments have resorted to health promotion tactics – many controversial – to those who oppose government intervention in their private lives. For example there are calls from some quarters to place restrictions and penalties on lifestyle choices such as the taxation of cigarettes. These restrictions and penalties on lifestyle choices will inevitably be used in wider contexts such as certain foods and risky activities, and these restrictions have the potential to undermine the fundamental aspect of justice: our basic freedom.

On the 23 March 2010, after a year of fierce debate, a health reform bill was signed into law in the United States. This bill is designed to ensure that ninety-five percent of Americans are covered by health insurance. It will also restrict insurance company practices, such as denying coverage to those with pre-existing medical conditions (BBC, 2010). It may seem strange to those who are accustomed to a universal government system of health care entitlements, but in a survey taken five days after this date, sixty-five percent of Americans said that the bill will expand government’s role in health care too much, sixty-four percent said that the bill will cost the government too much, and fifty-eight percent said that the bill does not do enough to curb rising costs (Page, 2010). This is after a long campaign by President Barack Obama to sell the benefits of the bill to ordinary Americans. Furthermore, as reported by the Financial Times, “...13 US states filed a lawsuit in federal court challenging the measure; just minutes after Mr Obama signed it into law. The states assert that the legislation violates states’ rights provisions in the US constitution” (Kirchgaessner, (2010). One may question the validity of these statistics and news stories as not being an accurate depiction of the sentiments of the American population. But assuming for the moment that these polls reflect real concerns, are there legitimate reasons why a majority of Americans are more than a little wary of this latest government intrusion into the health care system?

In this thesis I suggest that Americans are right to be wary of further government control of their health care system and of utopian promises of universal coverage of their health needs because publicly provided universal health care does not guarantee universal health care. This essay looks at

how theories of justice attempt to justify universal health care, by answering questions of what kind of care we owe each other in a just society. Adopting government-run health care does not solve problems of access, equity, or the availability of quality health care. Not only can universal health care not be provided publicly, but the theories that are used to justify publicly provided health care do not resolve the question of how much of one's own health and welfare should a person be expected to be responsible for, and how much we as a society owe each other. The diversity of health needs and their causes, as well as the complications that arise with health care distribution (namely rationing, threats to individual liberty, personal responsibility, and paternalism) is properly addressed by a pluralistic account of justice.

This essay seeks to find a theory of justice that can adequately inform current societies as to what they owe each other when it comes to health (including providing health care services and health promotion programs). In short, is there a universal and inalienable right to health? In order to try and find a workable theory, I will review some recent attempts to ground a right to health in a theory of justice. In particular I will examine the Rawlsian account of justice and health care by Norman Daniels and the Luck Egalitarian account by Shlomi Segall. Both of these theories can be used by those who want to find the one principle of justice that can be used to justify different forms of publicly provided health care services. I will examine what theory, if any, is best in providing health care while not overstepping on other important social goods and principles. I will argue that neither of these theories succeeds in providing a sufficient justification. I will then examine a pluralistic theory which I believe better fits in trying to justify a right to health. Principles of justice are important considerations in making day to day decisions in a health care system as well as more high level government policy decisions, and because of this I will be using David Schmidtz's pluralistic theory of justice in order to justify my conclusion that a right to health is not within the scope of just one principle of justice. I will argue that Schmidtz's theory allows us to pick and choose the best principle of justice that can be used for different aspects of health.

Finally I will discuss the limits to a right to health. No matter what theory of justice used to justify a right to health it must also help us understand what we as a society are willing to compromise when it comes to health care provision. I will argue that justice does not require attributing to "health" the status of a right as attempts to provide health care services to all threaten what many consider to be the core of a just society: freedom of intrusion and encroachment from external forces that would regulate the way we choose to live our daily lives. My paper aims to show that the complexities of health do not allow one conception of justice to be used to determine what kind of care we owe each other. Since the state of one's health can be caused and influenced by a myriad of factors, that one

principle of justice is inadequate to govern a health system that is equitable, comprehensive, cost-effective, and allows for individuals to choose to follow their own path in life.

As rationing health care services are inevitable in any health care system, I will cover how the theories can be applied to typical rationing decisions that policy makers as well as health care professionals must make in the real world. If a theory of justice argues that health care is a right, then the practicalities and nature of rationing are an important part of that theory being able to stand up to the test of real world situations.

II. Fair Equality of Opportunity

John Rawls and his theory of justice as fairness is the cornerstone to the theory of justice and health care proposed by Norman Daniels. Rawls's theory is based on a social contract between rational individuals in the original position, an ideal and theoretical state, where a contract is drawn between individuals who are behind the veil of ignorance (the individuals do not know what their real position in life will be, whether they will be poor, or powerful and rich). In this state the rational individuals decide upon what principles of justice must be upheld by the institutions and laws that are the basis for the social contract (Rawls, 2001, p. 16). The aim of Rawls's theory is to provide a foundation for democratic institutions to deal with claims of equality and freedom (Philosophy, 2008). The theory then is concerned with the institutions that make up the basic structure of society.

Rawls's theory is based on two principles of justice that he argues would be chosen by the rational individuals in the original position. The two principles are designed to ensure a social minimum that maximises the position of the worst off through the difference principle. They are also supposed to be harmonious with the good of each citizen in society so that they will have a stabilizing effect. Those who grow up with the principles should want to live by them (Stanford Encyclopedia of Philosophy, 2008). He claims that the principles of justice that the ignorant yet rational individuals decide upon must protect and give priority to certain equal basic liberties, rights, and opportunities. The members of the original position choose the principles of justice on the basis that they could possibly be the worst off, or be in a minority group so Rawls believes that the members self interest will make sure that the worst off have the difference principle to mitigate their inequality.

a. Rawls's First Principle

The first principle of justice says that all citizens have an equal right or claim to a system that guarantees equal basic rights and freedoms. This system must be the same for all citizens and only the rights that are specified in this scheme should be guaranteed. This is because, "... there are certain basic rights and freedoms of the person that are more important than others, and that are needed to characterize the moral ideal of free and equal persons" (Freeman, Rawls, 2007, p. 45). This is a democratic ideal as it is designed in order that all citizens have the ability to participate in civic life. It is also an idealization of the rational and self governing person who has the capabilities (and health) to fulfil their potential and find satisfaction in life. The first principle is not simply concerned with freedom per se, but that only certain freedoms are warranted protection in law. Basic freedoms must be inalienable, in other words, governments and democratic majorities cannot violate

them, and citizens cannot bargain for them or give them away. Losing one's freedom by being sent to prison, for example, is not a matter of rights being violated; it means that a person has forfeited their basic liberties by committing a crime. Just how a basic liberty is to be defined according to Rawls has been a source of criticism, but the following is a brief overview.

The five freedoms that Rawls considers to be fundamental are:

1. Freedom of conscience and thought;
2. Equal political liberties;
3. Freedom to protect integrity and freedom of the person (i.e. physical and psychological freedom from violence and coercion);
4. Freedom of association;
5. The rights and liberties covered by the rule of law.

Even with this list, however, determining what exactly counts as a basic liberty is not straightforward. But the freedoms in the above list are necessary in that they are the conditions needed for people to pursue a wide variety of life plans. After all, the first principle is designed to be applied from the stand point of a free and equal citizen. And the free and equal citizen is characterized as both reasonable and rational. They are reasonable in that they are able to understand and cooperate with others fairly, and they are rational in that they have the power to create, define, change, and pursue a coherent moral code. The reasonableness and rationality of citizens is what allows us to hold people responsible, and they are otherwise known as the two moral powers of free and equal persons. This conception of the citizen is crucial in defining the basic rights of the first principle as “What makes a liberty basic for Rawls is that it is an essential social condition for the adequate development and full exercise of the two powers of moral personality over a complete life” (Freeman, Rawls, 2007, p. 54). We have already seen, however, that basic liberty is not the end of Rawls's theory of justice. With this theory alone, some would have doubts as to whether this is a complete account of what justice entails and is left open to questions such as, what good do basic liberties do to those who are too poor to take advantage of these liberties? What good does political equality do for someone who relies on charity just to survive? It would seem that this kind of person would not value these liberties that cannot be taken away. Rawls's reply to this kind of concern is captured in his second principle of justice.

b. Rawls's Second Principle

Rawls's second principle of justice is designed to give liberty its worth and to encourage “... mutual trust and the cooperative virtues by instating an ideal of economic reciprocity” (Stanford Encyclopedia of Philosophy, 2008). Rawls acknowledges that without adequate resources, basic

liberties have only limited value, and therefore the aim of justice should be to make sure that liberty is worthwhile to everyone. The first principle therefore, is concerned with ensuring freedom in an institutional sense; the second principle, however, is primarily concerned with the distribution of resources. It is important to note, before moving on to the second principle, that it is no coincidence that the names of the principles are first and second, as the first principle is intended to be lexically superior to the second. This means that liberty must take precedence over the second principle, and liberty can be restricted only for the sake of liberty itself, and only when those with a lesser amount of freedom require compensation for this can the liberty of others be sacrificed. Once a certain level of wellbeing is reached by the least fortunate, it is not justifiable for liberty to be traded off or restricted for the sake of social goods (Philips, 1986, p. 58).

Rawls's second principle is the principle of fair equality of opportunity. This does not guarantee outcomes but only says that the rules and procedures must be fair. The basic structure of society should be such so that opportunity can be accessed by all. This can include measures like public education that are used in order to mitigate the effects of natural inequalities.

The second principle is designed to help compensate for disadvantages that one cannot necessarily help such as the family into which one is born, and one's natural talents, skills, and personality traits. Anything that shapes who you are in your life is designed to be mitigated by Rawls's principles of justice so that the worst off are better able to take advantage of their basic freedoms.

The second principle of justice says that inequalities must be arranged so that they bring about the greatest benefit for the least advantaged and must be open to all in terms of job positions and careers under the condition of fair equality of opportunity (Freeman, Rawls, 2007, p. 86). From the second principle we get the difference principle that requires that income and wealth must be distributed in such a way to maximize benefits to the more unfortunate groups of society, otherwise the distribution is considered unjust. The reason this is considered to be unjust is because we do not deserve, for better or for worse, the situation in which we were born or the natural talents we arrive with. Rawls does not believe that a person should receive greater advantages in life based solely on the fact that the gifts one has are valuable to the marketplace. The second principle also requires that the benefits that are received due to natural talents and abilities must be restricted in order that the least advantaged groups position can improve: "The accidents of natural endowments and the contingencies of social circumstances must be nullified. This is because, Rawls states, we must leave aside 'those aspects of the social world that seem arbitrary from a moral point of view'" (Philips, 1986, p. 59). This does not mean that Rawls is arguing for equal shares of resources. He is instead

arguing for the difference principle to mitigate the inequalities between the naturally endowed and unendowed.

c. Daniels' Application of Rawls

Rawls's theory does not at first glance seem to have much to do with health or health care. However, Norman Daniels uses Rawls's second principle as the primary justification for his theory of just health care. He does this by extending Rawls's theory and integrating with health needs to claim that "... meeting health needs promotes health...and since health helps to protect opportunity, then meeting health needs protects opportunity" (Daniels, 2008, p. 30).

i. The Right to Health as a Matter of Justice

Norman Daniels is a leading figure in the debate around universally provided health care, and he argues that in a just society we have a right to health. Daniels talks about meeting health needs, as the definition of health is broader than a certain list of health services. When he uses the word "health" he is using it as shorthand to characterize all relevant and controllable factors that affect population health and the distribution of health. Therefore, saying that there is a right to health is to say that there are certain obligations that we as a society must meet that affect the health of the population. For example, Daniels specifically mentions the following health needs:

1. Adequate nutrition
2. Sanitary, safe, unpolluted living and working conditions
3. Exercise, rest, and such important lifestyle features as avoiding substance abuse and practicing safe sex
4. Preventive, curative, rehabilitative, and compensatory personal medical services and devices
5. Non-medical personal and social support services
6. An appropriate distribution of other social determinants of health (Daniels, 2008, pp. 42-43).

Daniels argues that we have a right to health care, but only if it can be backed up by a systematic theory of justice. Without a systematic theory he says there is no way to sway people who are disinclined to think of health as a right and there is no practical way of managing disputes in the provision of health care. Daniels means for this theory to be much more rigorous as it is not enough to "... simply hope that if we all acknowledge such a right, we will unite behind the desired reform" (Daniels, 2008, p. 15). This theory is based on three focal questions.

The first focal question asks if health is of special moral importance. Daniels says that health is of special moral importance because it protects normal functioning of the human body and mind, which in turn protects the opportunities that are available to people (Daniels, 2008, p. 77). If protecting the

number of opportunities available to people is a moral duty, then meeting health needs is part of this moral obligation. Another way of putting this is that health is important because it helps our ability to achieve our life goals. There are some caveats to this. The first is that certain pathologies will harm one's opportunities more, depending on the society one lives in. For example, the inability to lift heavy objects due to a weak back will not limit the opportunity range for an accountant living in New Zealand as much as it would a farmer living in Zambia who needs physical strength to maintain a livelihood. Also within the same society, the same impairment will affect people's opportunity differently. So change the farmer living in Zambia to the farmer living in the Waikato. The special moral importance of health, in short, is that health needs have to be fulfilled to maintain normal bodily functioning, and protecting this means that we are protecting the range of possibilities that are open to people. Being of sound body and mind is essential to being able to choose a way of life from a broad range of options, rather than being limited to a certain way of life, because there are very few choices one is able to make.

Daniels appeals to John Rawls's theory of justice but with a subtle difference: Rawls assumes that those in the original position are not sick. Fair equality of opportunity in Daniels view, however, is connected to health. Health care is not a primary good, but when we talk about meeting health needs and distributing health care we are merely fulfilling the principle of fair equality of opportunity. Daniels argues that health is just as strategically important to fair equality of opportunity as is education (2008, p. 61).

The first focal question is also answered by the fair equality of opportunity, according to Daniels, because various theories of justice support the idea that we have an obligation to protect opportunity such as Sen and Nussbaum's theories of capabilities. Health contributes to the range of one's opportunities which means that health is therefore of special moral importance.

Rawls is not the only theorist that Daniels believes can be used in order to justify a right to health. Daniels turns to two critics of Rawls: Amartya Sen and Martha Nussbaum who claim that Rawls focuses on the wrong space as the target of justice. The proper target in their view is not opportunity, but capability: "Meeting health needs is crucial to sustaining capabilities for the same reason that it is crucial to protecting a fair share of the opportunity range: normal functioning is critical to both" (2008, p. 64). The term capabilities refers to what people can do or be, and Sen says that capabilities are a form of positive freedom, i.e., having freedom and the means of exercising that freedom. What is important to Sen and Nussbaum is not the index of primary social goods, but that people have an equal amount of capabilities. Extending Sen's principle of equal capabilities to health needs also has

dubious real life consequences according to Daniels. If what we are after is equal capabilities, then the goal of medicine would have to be changed so that those who have fewer capabilities but are physically healthy in a scientific sense would receive treatment so that their capabilities could be more equal to those around them. This is troubling to Daniels and in my view is a valid concern. However this is almost an entirely separate debate on our criteria for health needs, because it creates the problem of not being able to distinguish between what is considered to be an enhancement or a treatment. We would be obliged, under this theory of justice extended to health, to enhance the capabilities of perfectly healthy people who are less capable in some way. Despite this problem, however, Daniels believes that Sen's account of justice is still a close enough fit to his own extension of Rawls, partly because in practice it would demand a similar amount of distribution as the opportunity account, and recently Sen and Nussbaum have said that the capability approach only requires a certain level of equality in capabilities to be sufficient. Therefore, Daniels says that a modest capabilities account of justice also works well with his own extension of Rawls and a right to health. Daniels claims that this view is not really so different to Rawls, because the opportunity range is expanded the more capabilities someone has. In Daniels' view, they are talking about the same thing in reality; the only difference is the terminology, because Rawls's index of primary goods takes into account capabilities of citizens to meet their needs by distributing the primary social goods to them.

ii. Inequalities in Health

Daniels' second focal question asks when health inequalities are unjust. He claims that health inequalities are unjust when they result from an unjust distribution of certain factors that society has the ability to control and that affects or even determines the health of a population as per Rawls's theory. The kinds of controllable factors that Daniels is referring to are factors such as poverty, access to primary health care services, and safe working conditions, among others.

Daniels' theory of just health does not lead to straightforward answers regarding what entitlements will follow. His theory is designed to mitigate the disadvantages caused by ill-health. It does not aim to rectify all health inequalities as this cannot be done; it instead concentrates on obvious disadvantages. His theory is only meant to say that a society has an obligation to protect and promote health for all its members for the reasons already outlined. His definition of just health is that we should treat illness when it happens, reduce the risks of disease and disability before they happen, and distribute risks equitably (Daniels, 2008, p. 97). We are not just responsible for what happens once someone is sick; we are also responsible as a society to reduce the risk of people becoming sick

by making sure that we have invested in basic education, affordable housing, and other services. This is one way in which the health system (and other key players outside of the health sector) can protect the health of the population. But what are the implications of universal access based on Daniels' broad definition of health needs to public health and medical services?

Daniels says that public health should promote conditions that reduce the risk of disease or disability: "They reduce risks by assuring clean, safe living and working environments and by protecting against infectious diseases" (2008, p. 43). One example of this would be the banning of cigarette smoking in workplaces and indoor areas of bars and restaurants. For non-preventable diseases our obligation is to "... devote significant resources to such medical and social support services ..." (Daniels, 2008, p. 143), and use a careful and fair deliberation to determine proper allocation to prevention versus cure and social support. Personal medical services that are essential to promoting the fair opportunity principle must be accessible to all. Daniels gives us no clue, however, regarding how treating illness should be organised in reality. He claims that this could be done by a mixture of public and private insurance, as long as there are no financial, racial, or geographic barriers to accessing health care services. Daniels is not arguing that there is one unique kind of structure that is able to provide protection for people's opportunities. His theory is made vague enough so that it can be used to suit the needs and resources of different societies.

iii. Resource Constraints

Daniels acknowledges that resource constraints have a limiting effect to his theory. He says that while the first focal question gives us general directions for designing health systems and the second focal question gives us guidance for social policies that can affect health, they do not tell us what we should do when we reach resource constraints as the answers to his first and second focal questions are too general. Therefore Daniels asks, "How can we meet health needs fairly when we can't meet them all?" (2008, p. 103). His answer is based on two principles in a democratic decision making process: legitimacy and fairness. Legitimacy means making sure that decisions-makers have the moral authority to impose limits. What gives decision-makers legitimacy is that they follow a fair process that is supplemented to general principles of justice, which should make those decision-makers accountable for their decisions. Daniels also acknowledges that resource constraints are not the only limit, as health is not the only aspect that affects opportunity and opportunity is not the only important social good that we strive for. We must protect basic liberties for example, which means that Daniels is following true to his Rawlsian roots by taking into account the first principle that is

supposed to be lexically superior to the second. Daniels then sets four conditions that are important in ensuring that the limit setting process is fair and legitimate. These are that the process must be public, it must have relevance (must have value for money and must have relevant reasons), it must be open to revisions and appeals, and finally there is the regulative condition to ensure that the first three conditions are followed. Whether the decisions that are made in following this process are truly the right ones is not guaranteed. Daniels concedes that democratic decision making is not without its critics: "... whether there is any epistemic authority to democracy – whether it helps us get things right – lies at the core of much current debate about democratic authority" (2008, p. 138). But if the right process is followed, we do have some assurance, according to Daniels, that those who make decisions are at least held accountable for the reasonableness of their decisions.

III. Luck Egalitarianism

In the previous section, the discussion of Norman Daniels explained that meeting health needs is of moral importance because it promotes the normal functioning of the human body, which in turn promotes the range of opportunities, as well as capabilities, that are available to us. But health needs are quite often unequal, and certain medical conditions affect people in different ways. Inequalities in health are due to a variety of factors whether they are geographical, political, economic, or due to participation in health damaging and risky behaviour. Due to the variety of causes of inequalities in health, Daniels asks if all inequalities in health are unjust (Daniels, 2008). Daniels responds that health inequalities are unjust when they are avoidable, unnecessary, and unfair, and the way to address this is to implement Rawls's theory in order to distribute fairly the various social determinants of health (2008, p. 82). The Luck Egalitarian response to this question says that it is unjust for people to suffer negative consequences as a result of something that is either not in their control or is something that we could not reasonably expect people to avoid.

With this emphasis on luck and responsibility Segall frames his theory as a better alternative to Daniels' theory. Luck egalitarianism is an attempt to recognise the value that we often place on personal responsibility, and also plays to the resentment that many people feel towards those who are freeloaders on our social systems; who are worse off because of their bad choices rather than an act of God.¹ The luck egalitarian tries to bridge the gap between the left and the right of the political spectrum by offering, "... the left a way of responding to ... accusations that the left is insufficiently robust about individual choice, ambition, and responsibility" (Matravers, 2007, p. 72), while still arguing that we have an obligation to take care of the general health of the population. Luck egalitarianism is also sometimes referred to as prioritarianism, or 'responsibility-sensitive egalitarianism' and it tries to appeal to this tension or intuition that is evident in everyday moral thinking and political decisions, when we have to ask ourselves what we owe to each other.

Shlomi Segall and his brand of luck egalitarianism says that it is unfair for a person to be worse off than others due to reasons that are beyond their control, and that the point of justice is to level the inequalities that are owed to bad "differential luck." Similarly Richard Arneson says that the aim of justice is to compensate those who suffer from bad luck, and it is society's responsibility to make sure that the lucky transfer what they have gained to the unlucky. The reason why there is such an

¹ Wagner identifies this tension; as one of the main problems with the welfare state is that there is a tension between providing for those who are regarded as genuinely unfortunate, and those who are "... merely improvident, foolish, lazy, or cunning" (Esping-Andersen, 1990, p. 2).

emphasis on luck is explained if we use a different terminology. Instead of the distinction between good and bad luck we can use the terms choice and circumstance. This shows that luck egalitarians at the very core are concerned primarily with those who suffer inequalities because of their unfortunate circumstance before they are concerned with those who suffer inequalities as a result of their choices. One is able to argue that those who suffer from bad luck (or unfortunate circumstances) must have priority before we can reasonably be expected to take care of those whose unfortunate situations are a result of bad choices that we could reasonably expect them to avoid.

Segall applies luck egalitarianism to health in general, not just health care. Segall tries to distance himself from Daniels take by claiming that Daniels is concerned with, "... the instrumental value of health care to one's opportunities for life plans" (Segall, 2010, p. 95). Segall acknowledges that Daniels is concerned with health in and of itself as a focus of justice; he still says that the luck egalitarian concern with health is superior. This is because luck egalitarians are concerned with opportunities for welfare not just opportunities for achieving one's life plans. This concern is supposedly broader and superior as it "... provides a better account of our intuition that health is also important when it serves individuals who have completed their life plans" (2010, p. 95). Health care services are only a minor aspect to how healthy we are and therefore the discussion of justice and health according to Segall must be framed around health itself. As Segall claims that health needs in general are a more important focus than health care, I will first look at Segall's argument for luck egalitarianism and health before examining how he uses luck egalitarianism to determine how health care services should be distributed.

a. Segall's Luck Egalitarianism and Health

Luck egalitarians argue that the point of distributive justice is to level out inequalities and differences that occur on the basis of bad luck. For a luck egalitarian it is unjust if someone becomes worse off because of a situation that it would be unreasonable of us to expect them to avoid. If a person were to cross the road at the designated crossing point and had taken the necessary precaution of looking for oncoming traffic, and then became worse off because a drunk driver came out of nowhere and crashed into that person, this would be unjust. To rectify this situation then there is the implication that we as a society owe this person a certain level of care to make sure that they are not permanently worse off.

One of the requirements in the luck egalitarianism formulation proposed by Segall is that there has to be inequality. A situation is only unjust if someone is worse off than another, not if they are equally well or unwell: "luck egalitarianism properly understood is not concerned with matching individuals'

level of well-being to their respective levels of deservingness” (Segall, 2010, p. 19). For example, by this account we could argue that it is unjust for a person to be equally as well off as another person because they inherited a substantial amount of money while their neighbour had to work 30 years to accumulate the same amount of wealth. This kind of inequality does not worry Segall’s brand of luck egalitarianism, although there are luck egalitarians such as Richard Arneson who claims that, “Distributive justice stipulates that the lucky should transfer some or all of their gains due to luck to the unlucky” (Matravers, 2007, p. 72). Even with Arneson’s more radical take on distributive justice and responsibility, luck egalitarianism is not trying to match a person’s level of wellbeing with whether or not they deserve that level of wellbeing. It only seeks to bring up those who are unequal because of their bad luck.

Another aspect of Segall’s brand of luck egalitarianism is that his is a welfarist view as opposed to Dworkin’s resourcist view. A resourcist brand of luck egalitarianism is concerned with treating people equally by distributing resources equally: “Dworkin’s theory of equality of resources attempts to explain how that sort of distributional equality is derived from equal concern and respect for people” (Blake, June 2008, p. 172). Dworkin says that each person should be given an equal share of resources (or at least that should be the aim of governments) and should be free to do whatever they choose with that resource. Welfarist luck egalitarianism on the other hand is concerned with (put simply) equal opportunity for an individual’s welfare and that one may make a claim in a distributive theory of justice to shares insofar as they contribute to one’s welfare (Blake, June 2008).

The other requirement in luck egalitarianism is that we interpret bad luck, or ‘brute luck’ as something that has happened to someone that it would be unreasonable for us to expect them to avoid. The reasonableness or unreasonableness is decided by what we as a society expect. Therefore, the focus of the theory is on society, not on blaming the individual.

In the context of health, Segall argues, we are not only talking about the inequality in receiving health care services. This is similar to the broad definition of health needs that Daniels uses. Recent studies have shown that health care alone does not have an enormous amount of bearing on health and the amount of health inequalities in a society. Segall quotes Dan Brock who has said that

“...differences in access to and use of health care have only a negligible effect on health inequalities among social groups, in particular individuals of different socioeconomic classes. The crucial point is that differences in the incidence of illness and injury from social causes swamp the effects on health of differences in access to and use of medical care to treat that illness and injury” (2010, p. 90).

The determinants of health include, "...the effects of familial nurture in early life, social exclusion, unemployment, work ... the availability of social networks, substance addiction, diet, and transport" (Segall, 2010, p. 93). These are separate from public health measures that monitor things like drinking water, food safety, seat belt and helmet laws, and so on. Segall tries to go one step further than Daniels' definition of health needs and says that inequalities in health are determined mostly by one's genetics and socioeconomic factors that affect health directly. One study that Segall quotes says that: "while medical care can prolong survival and improve prognosis after some serious diseases, more important for the health of the population as a whole are the social and economic conditions that make people ill and in need of medical care in the first place" (2010, pp. 90-91). This kind of empirical evidence leads Segall to argue that health care in itself is not morally special, because it has a very limited impact on the state of one's health. Justice and health are still important, however, even to Segall, because, "... as long as there is health care there is a need for principles of justice to regulate its distribution" (2010, p. 93). He argues that because health systems provide a public service, there is a need for a theory to be able to find a reasonable and just allocation of this service. Policy makers, according to Segall, need a theory of justice in health in order to protect our opportunities for welfare as long as they don't conflict or make us ignore how justice in health fits in with theories of justice in general.

If social determinants of health are so much more important than health care, what does this mean for Segall's theory? As Segall has said that we have a duty to provide for people's basic needs, this will include health needs and therefore health needs are not special. Therefore, the degree to which health care is effective or not will not change the fact that we are still obligated to provide for basic health needs.

However Daniels, Segall argues, is too preoccupied with the provision of health care rather than correcting the social determinants that lead to inequalities in health. Segall does not think that this is a big issue for luck egalitarianism, because he argues that focusing on health allows us to understand more generally the nature of justice. However valuable Segall sees theories regarding the distribution of health care, he still sees health in general as the main focus of his theory. Thus drawing a distinction between health care as a social good and health as a natural good allows us to see why justice and health is a special sphere. Segall says, "Since individuals already possess varying degrees of health, when discussing justice in the distribution of health we inevitably discuss existing *inequalities* in health" (2010, p. 97). This will have political ramifications when we make resource allocation decisions as members of a political community, as we must decide what inequalities we can consider to be just, and what inequalities are unacceptable in a just society.

As stated above, Segall argues that health is no more special than other basic needs that we have a duty to provide. If health does not have that special sphere then why bother theorizing about it in particular, one may ask? Segall argues that philosophers have a valuable role in assisting policy makers in the World Health Organization for example, in ensuring that the allocation of health resources is distributed justly.

b. Luck Egalitarianism and Health Care Distribution

Health care, according to Segall is a “normatively nonexcludable good” (2010, p. 78), as it is morally impermissible to deny medical care. For example, it is not morally allowed that we as a society would let people bleed to death on the street. Health care to Segall is in the same ranks of public goods such as clean air, and is an entitlement that we as a society must provide universally and unconditionally. However, this unconditional entitlement also gives society the right to impose the costs of treatment on those who need medical treatment based on avoidable decisions that they have made. Segall claims that the imprudent could say that it is not their fault that society cannot treat them and it is unfair to be penalized because one has been reckless with one’s own health (Segall, 2010, p. 79). Segall concedes that this kind of libertarian objection may seem like a weakness, but in reality is not very persuasive to an egalitarian. Health care as a public good is not exclusive to citizens of a country either, as health care should be a good that does not distinguish between residents and tourists simply because we feel a stronger connection with our fellow citizens rather than foreign tourists. Instead, health care should be spatial so that whoever is within our political boundary and is in need of medical attention should be treated in the same way that a citizen would. Health care is still a scarce resource however, so Segall uses luck egalitarianism to show how health care resources may be distributed.

If we ask therefore, what compensation we as a society owe to individuals, a luck egalitarian would respond: “Outcomes that it would be unreasonable to expect individuals to bear on their own” (21). This answer begs the question, how do we define what is reasonable or unreasonable? It also causes us to ask whether Segall’s theory is really as concerned with luck as he asserts. Segall argues that the ambiguity of what is unreasonable or not gives the theory its strength as it allows us to judge situations and outcomes on a case by case basis.

But what Segall sees as a strength to his argument, leaves his theory open to many counter examples that have the potential to discredit the luck egalitarian account of justice and health. It would be easy

to agree in some situations on what is reasonable or not. Almost all reasonable people would say that it is reasonable for us to expect people to not overdose on a substance widely known to be harmful such as heroin. But could we say that it is reasonable for us to expect the overdoser to bear the responsibilities of overdosing on his own? Most people would agree that it would be unjust to let those having taken overdoses die by denying these people at emergency rooms unless they had some kind of insurance. This is where we come to the abandonment objection to luck egalitarianism. The objection that comes from strong critic of luck egalitarianism, Elizabeth Anderson, claims that "...luck egalitarians are harsh on victims of option luck... for they abandon such victims to their dire fates" (Segall, 2010, p. 58). Segall replies that while a strict luck egalitarianism response would indeed leave imprudent people abandoned, his account would not because he claims that a luck egalitarianism guide to public policy would include other considerations such as "meeting basic needs" or "autonomy" (Segall, 2010). If luck egalitarianism when used as a guide to public policy must be supplemented with other considerations that are important to justice, it only shows that luck egalitarianism alone cannot be used to justify universal health care. Even Segall admits that his criticisms of Anderson and Daniels could be overcome if they were coupled with other principles of justice: "If that is the case, then the end I achieve in this part of the book is slightly more modest than I would have liked" (2010, p. 73).

The abandonment objection is overcome in Segall's theory not so much by starting with luck egalitarianism and supplementing it with other theories, but by assuming that there is already a principle in place that luck egalitarianism builds on. This assumed principle is that we have a duty to meet people's basic needs. He claims that meeting basic needs, including basic medical needs are already a prior duty that we as a society owe. He claims that meeting basic needs is our inalienable duty and is a moral requirement in its own right separate from health: "...there is something special about basic needs, and not necessarily about medical needs" (Segall, 2010, p. 76), and the special status of basic needs overrides the luck egalitarian brand of justice and therefore he claims that he is able to override the abandonment objection. He says that medical needs are not only the needs of those who are considered unhealthy, as we would not call pregnancy and childbirth illnesses however, these conditions require medical attention and hence should be attended to in a just society. This requirement to meet basic needs in fact is not important in the context of health in particular, but is important to justice in particular: "The concern for basic needs thus overrides luck egalitarian distributive justice and mandates meeting the basic medical needs of the prudent and the imprudent alike" (Segall, 2010, p. 76). Segall has tried to show us that luck egalitarianism can withstand the abandonment objection by taking in outside considerations such as an a priori requirement that basic

needs are provided for including basic health needs. One can reasonably ask then, where personal responsibility for one's choices comes in to the equation.

Segall says that if society provides universal coverage for medical treatment, then under the luck egalitarian theory those who require medical care because of their imprudent decisions and actions may be forced to pay for some of the cost for their own treatment. This should be done through a compulsory insurance program that makes those who engage in risky activities pay for at least some of the burden of their treatment. Segall says that this kind of compulsory insurance system should be a form of taxation that would be required before one were to engage in an unhealthy or risky activity. This would be a progressive tax so that the rich could not abuse the system, and to cover activities that the wealthy tend to engage in such as skiing. A compulsory taxation would also make sure that those who are injured through reckless behaviour would not turn down medical care to save money as they might if they were forced to pay a tax after the fact. Another consideration that Segall suggests is that imposing a tax on certain risky activities after the fact forces health care professionals to make determinations as to whether or not the patient is to blame for what's happened to them. This would change the role of these professionals from providing care to regulatory officers (which he thinks will be avoided by a compulsory medical insurance scheme that taxes people before they have acted riskily). If patients were forced to pay taxes after they had caused themselves harm from risky behaviour there is the potential that they would be less likely to trust their doctors, and patients who seriously need medical intervention may avoid seeking medical help altogether. This whole new layer of taxation is already in place for some who engage in what policy makers determine as risky behaviours. In New Zealand there is a high-level and ever-increasing rate of taxation on tobacco, and there are high levels of ACC payments on certain activities such as registering a motorcycle. This imposition of additional fines for risky behaviours is not a requirement for Segall. He only wants to make the point that the imposition of a tax on risky behaviours is legitimate if they are necessary for the sake of financing universal medical care. It is not designed to be a moral tax.

There are those who would argue that leading a risky and unhealthy lifestyle does not in fact impose a burden on the system. Reckless individuals quite often die earlier than "Prudent individuals [who], in contrast, present the health care system with many more life years during which they might require treatment" (Segall, 2010, p. 83). If that is so, then there is no valid reason to impose an extra tax on these people. In fact, maybe we should be giving smokers an allowance to say thank you for dying earlier and not making us foot the bill for their geriatric care. These estimates of what kinds of people cost the system more are debatable, and as Schmidtz says, "We live in a world of incomplete

evidence. Statistics appear conclusive, but in fact are not, and will some day be outdated in ways that matter. Data will be compatible with multiple interpretations, subject to refutation by further data” (2006, p. 138). Given that statistical evidence can be misleading or incomplete, we must take this scenario as hypothetical. If smokers do indeed end up saving the health care system money while healthier people end up costing the health system more, then what can luck egalitarianism say? This, says Segall, would be an excellent situation for the luck egalitarian as it gives a handy ‘out’ to the abandonment objection as we would not have to be harsh to those who smoke or have other unhealthy lifestyle habits. It also would not follow according to luck egalitarianism that we would have to penalize the healthy as the justification for passing on the burden of treatment to the imprudent was that they were burdening the health system for reasons they could control, for unnecessarily going skiing or climbing dangerous mountains. Even if smokers dying early would save us money, however, Segall says that we are still justified in imposing a tax on this behaviour as it is still an unnecessary expense that we have to pay to deal with the consequences of smoking, and these resources could be spent elsewhere. It should be noted that taxing certain behaviours is not just about recouping the cost of treating these patients. In the case of smoking the justification for increased taxation and restriction on the sale of cigarettes is in an effort to decrease the rate of smoking by imposing disincentives for people to start smoking in the first place. According to statistics from the OECD, this appears to have been successful.²

Segall’s theory of health is not justified by luck egalitarianism. Luck only comes in to consideration when talking about health care distribution. So it has nothing to do with establishing whether health care is a right. Bad option luck is only a consideration that Segall thinks, could rather than must, be used to limit distribution. And in fact it is not meant to limit distribution but to make people pay more.

² The proportion of daily smokers among adults has shown a marked decline over the past twenty-five years in most OECD countries. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation. Smoking rates among adults in New Zealand have decreased from 30.0% in 1985 to 20.7% in 2006, a rate lower than the OECD average of 23.7%. Australia, Canada, Portugal, Sweden and the United States provide examples of countries that have achieved remarkable success in reducing tobacco consumption, with current smoking rates among adults in the range of 16% to 18%. (OECD)

IV. A Pluralistic Approach

The two theories discussed thus far have all been concerned with the distribution of society's scarce resources and the opportunities that are available to individuals to take advantage of these resources in the context of health. David Schmitdz, in his book *Elements of Justice*, does not speak specifically about health but his theory of justice can be applied to questions regarding the shape and limits of a right to health. Schmitdz starts with the basic definition of what justice is: justice is what people are due. He says that while he does not focus on spheres of justice, he focuses on the many contexts that we experience in our daily lives, and calls on a principle (or element) of justice to suit that context. The elements of justice that he discusses are essential to my argument, in showing that both Daniels and Segall's efforts to find one kind of theory to justify universal health coverage has the potential for oppression to occur in the name of a single principle of justice.

Schmitdz describes his theory as 'contextual functionalism' (2006, p. 17). The four primary principles of contextual functionalism are reciprocity, desert, equality, and need; the theory is pluralist as he says that no one principle is so superior that all others can be reduced to it. It is a contextual theory in a similar way to Michael Walzer's spheres of justice (Schmitdz D. , 2006, p. 17), in that he does not believe that there is only one overarching conception of justice that can inform us what is just in every given context, and that each principle can only be used to some degree for a certain range of topics. The borderlines between topics are fluid, as they can change over time and in some cases can overlap and clash with each other, and therefore the specific details of a situation will inform us as to what principles should be used in a given situation. Schmitdz says that while his theory is similar to Walzer in some ways, it is also very different because Walzer's spheres are relative to a community, and Schmitdz's functional contextualism is not designed to be relative to different communities and therefore is not meant to be restricted to a certain geographical area. Schmitdz says that his theory is 'functionalist' because its aim is to resolve uncertainty over what is just in a given situation by making us ask what justice is meant for (2006, pp. 10-11). This is important because there are often considerations that are outside the scope of justice, and some of them matter. In the case of health we can say that the considerations of resource constraints, for example, matter even when they are not within the scope of justice.

Schmitdz says that a theory of justice is like a map to the neighbourhood of justice. A useable map will have enough detail so that we can find our way around although it will not tell us how to get there, and will not tell us the potholes that we might find along the way to use Schmitdz's metaphor (2006, pp. 22-23). He says that we can see that using one overarching principle to cover everything is

like using a map of the globe to find the way from one part of a city to another. In the same way, overarching principles, as ambitious as they are, do not help us in making moral decisions that are required of us on a daily basis. In applying principles of justice, therefore, we need the wisdom and experience to determine what principle of justice is the best to use in a given context. Wisdom and experience are crucial to Schmitdz in the same way that choosing which map to use to find ones way. The map is not enough as it does not tell us what to do at a given moment unless we already know from experience where we are: “Ordinary maps depend on a user to know where he or she is, and where he or she wants to go” (Schmidtz D. , 2006, p. 23). In order to navigate the realms of justice, even with a map it will be left up to interpretation and is why Schmitdz argues that we should consider other factors outside of justice when deciding which principle is best to use. In viewing theories as maps, we can see that theories can overlap. Just because a map is slightly out of date and inaccurate does not mean that it needs to be thrown out. In the same way, we can see that just because there are elements to a theory that do not add up, does not mean that there is nothing of value to be learned from that theory.

In Schmitdz’s pluralistic account of justice, we must first determine the context, which of course in this paper is health, before determining what principle of justice is best suited to answering the question of what we are due. However, health in itself is a complex issue. It is a mix of genes, lifestyle choices, environmental factors, the availability of resources, economic conditions, and the state of medical knowledge and practice at any given time. It is impossible in my view to use just one principle of justice to confront all of the controversies in every context of health, health-related issues, and health care service delivery decisions that arise when we ask if we are due a right to good health as a matter of justice. Rules of justice, Schmitdz claims, “...tell us not only what to expect from each other, but what to count as an affront... Strangely, if... [a] theory fails to condemn things we consider an affront, that in itself is a bit of an affront” (2006, p. 5). Instead of looking at the health of a society with the view that those who are unhealthy must receive treatment and support otherwise an injustice has occurred, we must look at the unhealthy and say is there a way of inducing those who are unhealthy because of their lifestyle, into taking responsibility for themselves without infringing on their freedom?

Following Schmitdz’s lead then, I will use Schmitdz’s four principles to examine different aspects of health to uncover what principle or principles of justice are best used in the different contexts of health.

a. Desert and Health

The principle of desert says that people deserve a chance to be given opportunities in life to make the best of situations that have been given to them (Schmidtz D. , 2006, p. 49). People deserve a chance to succeed in life whether or not they have made mistakes in the past that some would argue exclude them from being considered deserving of assistance. The principle of desert then has a compensatory aspect as well as a promissory aspect: that we can get what we deserve (or have earned) by looking at what we have done in the past, and also that we can be given the opportunity to succeed in something by taking advantage of an opportunity. The best way we can do that according to Schmitz is to acknowledge that a view that only takes into consideration whether someone's past makes them deserving is too narrow. As Schmitz says, "The most valuable things we are given in life are opportunities, and the main thing we do to deserve them is to do justice to them after the fact" (2006, p. 53).

Additionally, desert is not about analysing how deserving one person is in comparison with another. The principle is simply about respecting those who "...do what they can to be deserving of their advantages" (Schmitz D. , 2006, p. 63). For example, let us say that there are two individuals who have both made it their goal to complete an Ironman triathlon. Both train for an equal amount of time and have the same amount of determination and discipline to do the required amount of training. However, while the effort they have put in has been similar, Athlete A has won the genetic lottery and has the natural ability to be able to work harder for longer and recover fast from strenuous workouts, and also has a natural lean, strong physique. On top of all that, Athlete A has a strong background in swimming, giving him an edge. Athlete B on the other hand has a genetic propensity to retain and put on weight easily, does not have a strong athletic background and does not have the same amount of stamina to get through and recover from workouts as Athlete A. When it comes to race day, Athlete A finishes the race at twelve hours, while Athlete B finishes at fourteen hours. Because the principle of desert is non-comparative, we can say that not only did both athletes deserve their result, but that Athlete A did not deserve his score any less because of the advantages that were on his side.

One health issue that we can apply the principle of desert to is the population health crisis of obesity. A health issue such as obesity is complex. There may be many reasons why individuals are obese, as some individuals may not have been taught as a child that taking care of their health is important, they may be in denial about the effect that their lifestyle is having on their physical and mental health, or eating may be a coping mechanism for some who deal with a trauma in their life or with

general unhappiness or boredom. Additionally some studies have shown that a person's weight and body composition are determined largely by our genes. One study in particular found that "body-fat percentage is 64 percent inherited. Lean parents tend to have lean children and fat parents tend to have fat children, regardless of differences in lifestyle" (Fitzgerald, 2009, p. 26) (Hsu, 2005). In this scenario, we must ask whether those who are engaging in a health threatening activity are due any intervention or help from society. It may seem harsh to claim that the negative effects of obesity are an affront to others. This is indeed harsh if one's obesity does nothing to negatively affect members of one's family or community. However, when a certain segment of the population expects others to pay for the treatment that is caused by what many might perceive to be their irresponsible actions, this does seem like an affront, and it is easy to see that over time this could cause resentment and marginalization of all who are overweight as lazy and irresponsible. This is of course a stereotype that would be wrong to base any kind of public policy on, as I have just mentioned that the causes of obesity are not straightforward for many people, and the fact that it is biologically difficult to lose weight even if one tries does not make it any easier. The question still remains though: do we have a moral obligation to help the obese by funding weight loss initiatives, taxing unhealthy foods, or providing funding to risky and costly procedures such as gastric bypass?

The answer to this question will be equally as complex as the causes of the problem. Schmidtz says that we must consider whether there is a negative externality to one's actions (2006, p. 11), and in the case of the unhealthy lifestyles of western countries, one can easily point out the negative externalities. Obesity causes an increased risk of chronic illnesses such as diabetes and heart disease. Both of these are burdens on the health system, and therefore, in a country like New Zealand are a burden to all taxpayers. If our answer to this solution is simply to fund gastric bypass surgeries to those who need them as Daniels would argue is necessary, so that those who are obese will have more opportunities in life in the future, then this does not resolve the negative externality conflict. As Schmidtz says, "...if practicing a principle leads us to take responsibility for the consequences of our actions, then not only is it apt for resolving conflict; it also functions like a principle of justice, for it requires paying some attention to what people around us are due" (2006, p. 11).

Rules of justice tell us what we should expect from one another. A reasonable person might say that they expect others around them not to pass on the negative effects of their lifestyles to us. This is one sensible objection for banning smoking in public places such as restaurants and bars. It is perfectly reasonable to require that the smoking habit of one person should not negatively affect others.

An objection to using the principle of desert in the case of obesity is that there are many causes of obesity that are outside the control of the individual. Genes may have a lot to do with who becomes obese and who does not. But can those who are not obese take credit for their healthier weight? One could argue that one does not deserve praise for being healthy and fit, because it was not something that they chose to do. This seems to be the case if it is not fair to assign responsibility to the obese.

It seems that we are left with two choices in this case. Either we take a very harsh stance against those whose ill health is caused by their own choices as luck egalitarians would argue is fair, or we as a society take on responsibility for dealing with the consequences of their ill health. Both choices we have already seen have undesirable outcomes and dubious incentives attached to them. The harsh stance will leave some in need and, in a sense, leave them outcasts in society because of their unwise choices and habits. Taking responsibility for these people as a society leads to dubious incentives as it will not tempt many into taking responsibility for their own health and at the same time forces the general public to pick up the bill for those who cannot afford to pay for the consequences of their actions. There is a third way, however, thanks to the principle of desert, that allows us to take a more compassionate stance, allows justice to be done, and allows individuals the chance to be empowered to take responsibility for their own lives. This third way is made possible because of the principle of desert that allows us to uphold justice and promote individual responsibility.

The principle of desert in its promissory sense could justify intervention. Maybe we owe people with preventable health problems a certain number of chances, or certain kinds of chances. We might decide as a society that we deserve to give children a chance to learn how to be healthy and to help them acquire some of the life skills of healthy living especially in cases where children do not learn this at home. A program that would be congruent with the principle of desert (in the promissory sense) would be focused on early intervention to teach children how to live well before they reach such a degree of ill health that drastic measures such as gastric bypass are considered. For young people and adults one possible option is that access to a dietician could be subsidised in cases where an individual is wishing to change their lifestyles but needs extra support. These are only two examples of possible interventions that focus on giving individuals a chance, without guaranteeing expensive and labour intensive medical interventions.

b. Reciprocity and Health

Principles of reciprocity, according to Schmidtz can play important roles in justice, but can they play a role in the context of health? First we must outline Schmidtz's arguments for reciprocity.

Reciprocity is defined as, “When you can return good in proportion to the good you receive” (Schmidtz D. , 2006, p. 76). Reciprocity is not that a person does something kind in order to get something good back, but it is about those who receive kindness being “...gracious in acknowledging favours” (Schmidtz D. , 2006, p. 77). Reciprocity is essential to how we behave in all our social relationships whether personal or business. It is important because it helps to reinforce good behaviour: “When people reciprocate, they teach people around them to cooperate. In the process, they not only respect justice, but foster it” (Schmidtz D. , 2006, p. 79). Fostering justice and gracious and kind actions can hardly be argued against in our personal lives, but can this apply to health and the central question in this paper? In the context of health, this principle of justice cannot tell us very much about what we owe each other. It is hard to see whether public policy decisions could be made on the basis of reciprocity and health. This is not to say that it could have no part to play at all. In the context of health, reciprocity could be used in the sense that when someone is given a certain chance to live a healthier life, for example a life-changing surgery or life-saving procedure, it would be just for that person to pay it forward by using their new found health to contribute to their community in some way. For example, someone who has received chemotherapy and has recovered from cancer might volunteer in an NGO that supported cancer patients. This would be an admirable action and one that graciously acknowledges what a new chance on life means. Crucial to this principle of justice, is that it cannot be regulated. Furthermore, since reciprocity really is a personal element of justice, it runs the danger of biasing public policy decisions if those in charge of making these decisions are biased towards paying back some kind of debt they felt they owed to a particular group. This would be an abuse of power in the name of reciprocity.

The principle of reciprocity could be an integral part, however, in the way that government-run health programs interact with private health providers. Even in countries that have universal health care systems set up, publicly owned and managed health care providers are not the only providers on the scene. In many cases publicly owned hospitals in New Zealand cannot cope with the demand for surgeries and District Health Boards are forced to contract out significant numbers of surgeries to privately owned hospitals. Under the current National government this practice in fact has been encouraged in order to cut down waiting list times. The World Health Organization (WHO) is also a key organizer in public-private partnerships for worldwide health initiatives such as developing vaccines, education, and providing and distributing medicines for diseases such as leprosy. If ideology of those in power is too skewed against the idea of private companies and non-profit organization’s ability to aid in the promotion of health, then the only people who suffer are patients. There is no real reason why public and private agencies cannot find a way to work together to

provide the best outcomes possible. Fostering justice and peace between governments and private organizations may sound overly optimistic, but if reciprocity were taken seriously, not in regulation, but in the code of conduct between health care providers no matter what their legal status, this could potentially have a huge impact in the quality of health care that is provided.

Reciprocity should be promoted in interpersonal relationships, and is a strategic way of getting along in many areas of life, and as with the other principles, it is not meant to act on its own as it is only one element of justice.

c. Equality and Health

We come now to a crucial element of justice for health: equality. Schmitz argues that there is only a very limited place in justice for distribution according to principles of equality. He says that while justice has much to say about equal treatment, there is less of a connection between justice and equal shares. Even in egalitarian theories, there is acceptance of some degree of inequality, for example, Rawls's theory allows for a certain amount of inequality as long as society prioritises the worst off as much as possible. An egalitarian "...is someone who embraces one kind of unequal treatment as the price of securing equality of (what he or she considers) a more important kind." (Schmitz D. , 2006, p. 110). We can see that this was true in the case of luck egalitarianism in that Segall claims that it is justified that those who engage in risky behaviours be made to pay extra before engaging in that behaviour in order to compensate for the medical procedures that they may or may not need.

Egalitarianism in Schmitz's view cannot separate itself from humanitarian concerns; otherwise egalitarianism is solely about equality for equality's sake. Equal treatment as an element of justice is a humanitarian concern. Humanitarianism says that suffering is bad in itself whereas egalitarianism is about how people are relative to one another. Elizabeth Anderson's views are closely aligned to Schmitz in this principle as she says that the proper aim of justice in her own words is "...not to eliminate the impact of brute luck from human affairs, but to end oppression, which by definition is socially imposed. Its proper positive aim is not to ensure that everyone gets what they morally deserve, but to create a community in which people stand in relations of equality to others" (Anderson, 1999, p. 289). The fundamental aim of entering a social contract and constructing a state according to Anderson is to secure the freedom of individuals; therefore resources are distributed in order that equality of basic democratic capabilities and freedoms are ensured. Anderson objects to luck egalitarianism because she argues that the focus on equalizing is done for the wrong reasons. For example she argues that it is wrong for the point of equality to be about compensation for brute luck as it is disrespectful because we pass judgement on how equal we are based on our inferiorities.

Schmitz makes the excellent point that political equality does not assert compensation or equality based on inferiority, instead it asserts its right to equality on the fact that we are truly equals in the political community no matter what inequalities of wealth, status, or the physical characteristics we are born with. This is why egalitarianism cannot lose its connection to humanitarianism: inequalities are not in themselves unjust unless they are inequalities that are inhuman. Therefore, he says, “Egalitarianism cannot afford to define itself by contrast with humanitarianism. No conception of justice can afford that” (2006, p. 115). Pictures of starving children in war-torn countries do not move us in more stable and wealthy countries just because they have less than we do. They move us because of our humanitarian concern that they are suffering. If they had less than us but were perfectly happy, healthy, and with bright prospects for the future, then we could be vastly unequal in wealth and even opportunity but the situation would not be necessarily unjust.

Different kinds of equality matter more or less for Schmitz and Anderson as well. “Political equality is called for even when economic equality is not” (2006, p. 115). With the connection of equal treatment and respect that is informed by humanitarian concerns, there seems to be a straightforward connection to health. Illness can cause great physical and emotional suffering to individuals and their families, and there are a huge number of measures in place in developed countries to prevent the outbreak and spread of preventable diseases by putting in measures that regulate and monitor the safety of food, drinking water, sewage systems, vaccinations, and so on. It should be obvious that these kinds of measures should apply to all in a society, so that sewage systems and water supply standards are the same in wealthier neighbourhoods and poor neighbourhoods.

Beyond these kinds of health measures, however, there are a large number of inequalities in health that many studies have shown are caused by or correlated with inequalities in socioeconomic status. For example, in a Canadian report on the social determinants of health, those who suffer from

“...adverse material and living conditions also experience high levels of physiological and psychological stress. Stressful experiences arise from coping with conditions of low income, poor quality house, food insecurity, inadequate working conditions, insecure employment, and various forms of discrimination based on Aboriginal status, disability, sex, or race. The lack of supportive relationships, social isolation, and mistrust of others further increases stress” (Raphael, 2010, p. 10).

If one suffers from chronic levels of stress from one of the causes in the quote above, this can lead to negative reactions in one’s body and people can become susceptible to conditions that can affect the immune system as well as the cardiovascular system and make one more likely to develop adult-onset diabetes. High levels of stress, hopelessness about life, and the struggle of just trying to get by can make it easier to form self-destructive habits such as taking drugs whether legal or illegal.

Schmidtz's take on the principle of equality allows us to meet this kind of concern, however, not because inequalities exist in society, but because those who are suffering from stress and increased likelihood of negative health outcomes are suffering. We must determine how we can best support and encourage those who feel hopeless about life to feel empowered. This cannot be done by focusing solely on inequalities.

Schmidtz talks about two ways of looking at the world. One is from a static perspective, where the view is a 'snapshot' and we can see that some people have more than they need and others have needs that are extremely under met. This makes us question how we can provide adequate resources to those with unmet needs, how we can stop the system from leaving people behind. From a dynamic perspective on the other hand, we can see many snapshots at the same time and analyse how the picture we had of society at one time changes and then ask what kinds of institutions help the needy to exist in the first place. Looking from a dynamic perspective, one would worry about redistributing resources according to what we would like our snapshot to look like rather than "...the purposes for which producers are producing them" (Schmidtz D. G., 1998, p. 6). Looking from the static perspective, one might think that the dynamic point of view is heartless to hesitate to redistribute wealth. However, Schmidtz argues that it is important to look from both perspectives so that we not only look at ways to resolve current problems, but also have the resources and foresight to build into our institutional mechanisms that encourage personal responsibility, making outside intervention unnecessary for more and more people.

When Schmidtz talks about personal responsibility, he is trying to make a distinction between "...internalized and externalized responsibility..." (1998, p. 8). A responsibility is externalized when a person does not take ownership for a mess that they either cause or are just involved in. In the context of health care, we could give the example of someone who has reached an extreme state of morbid obesity and expects public money or insurance to pay for surgery and other medical care. Responsibility is internalized when a person takes responsibility for their own wellbeing, future goals, and the consequences of their actions. You could use an example of someone who has reached the state of being obese but takes the initiative to lose weight by adjusting their lifestyle in order to take care of their own personal health, but also in order to make sure that they are able to provide for the health and well being of their family in the future. Collective responsibility can either be internalized or externalized. Collective responsibility is internalized when a member takes care of themselves as part of a group, out of a willing sense of duty to be a proactive and contributing member to their community, or when families make sure to take care of and support one another. This is not an issue to Schmidtz, but collective responsibility does worry Schmidtz when we fall for

the temptation of externalizing responsibility. For example, saying that guaranteed provision is necessary in order to make people better off is one way of externalizing responsibility. Universal health care does not mean that health care is free. It only means that the person receiving treatment may not have to pay at that moment, but we are all paying for it through taxation. We as a community are paying for not only the health care service, but the institutions and bureaucracies that enact and manage health care services. Bureaucracies and health services do not operate on goodwill alone. What it means is that "...people have to pay for other people's needs and other people's mistakes instead of their own" (Schmitdz D. G., 1998, p. 9). This is not a free pass to start blaming people for their actions as tempting as it might be. Schmitdz makes another distinction between holding someone responsible (which means that you are blaming them or giving them credit) and taking responsibility (which means that you take on the challenges of life the best way you can, no matter if you are faced with good or bad luck). In an institutional sense, we should favour those institutions that encourage and lead people to take responsibility for themselves rather than those that hold people responsible.

Schmitdz says that society is not a race, as in a race we start out at the same starting line, and we measure our relative performance to this starting line. Society is not about measuring our performance but simply about being a decent place to live. A place where we do not face arbitrary discrimination, a place where we have a chance to live as free and responsible citizens. "People need a good footing, not an equal footing" (Segall, 2010, p. 117). Reformulations of equality by those such as Arneson, are an attempt to improve people's prospects, although a misguided attempt as they focus too heavily on inequalities per se. Schmitdz says that progress is not about equal opportunities, it is about better opportunities. Removing barriers should not be important because they contribute to inequality, but because they are barriers. Similarly, addressing the root causes of the social determinants of health is important, not because they contribute to health inequalities, but because they affect the health and well being of members in our society. The same thing goes for equality of opportunity. As opposed to Daniels, better outcomes should be sought because good health is an important humanitarian concern, not because health affects opportunities alone.

d. Need

Society is better off, according to Schmitdz when people are able to meet their basic physiological needs and can afford to look beyond these to ask questions about what life is really about. (164). In the context of rights, what people need is looked at with a view to what people have the right to

claim. When talking about need as a principle of distributive justice, Schmitdz says that it must pass the test of what he calls “self-inspection” (Schmitdz D. , 2006).

The test of self-inspection asks whether need-based distribution will meet the need that it is intending to meet. Distributing according to need is about problem solving, not about making ourselves feel better (Schmitdz D. , 2006, p. 166). There are many needs out there in the world but in most cases distributing resources according to this need will not guarantee that the need is met. If we are really serious about meeting needs in our society we need to figure out what will work to meet that need other than distributing resources: “Need-based distribution can fail the test of self-inspection because alternative principles frequently are more conducive to people meeting their needs” (Schmitdz D. , 2006, p. 167). We have to ask ourselves then in this context whether bringing in universal health care policies will really address health needs or is it just a way for us to feel better about ourselves without really addressing the causes for the state of bad health? In some cases universal care and policies will improve health, such as emergency care and preventive measures such as food and safety standards, vaccines, and education programmes regarding the importance of hygiene, for example. But as both Segall and Daniels point out, the majority of causes that affect health are in fact not related to the availability of health care, but are those social determinants of health such as income, stress, working conditions and social exclusion. It does seem then that we can argue using Schmitdz’s principle of need that there are some kinds of health care provision that can be provided universally according to need, because providing a specific service will address that need, while other services that could be provided will not properly meet the need they are trying to address. A prime example is health needs in pregnancy and child birth where proper medical attention and advice are key to the health of both mother and child. Providing maternity care is a need that can be directly met by medical intervention during pregnancy and during labour. Meeting this need does not mean that this has to be done in public hospitals.

Other health needs are not necessarily met best by providing health care, but are best met by encouraging and educating individuals on how to improve their health and prevent illnesses by making positive changes in their lifestyle. In other words many health needs are best met by encouraging individuals to take ownership of their own health, and by showing ways for people to take responsibility for the state of their health. If a person has a running injury, this is often not fixed by an occasional visit to a physiotherapist alone. A physiotherapist will likely prescribe exercises and stretches that the individual should be doing on a daily basis in order to rehabilitate their injury. If the individual does not comply with these recommendations no additional appointments are going to fix the injury. It is up to the individual to take charge if they wish to recover and get stronger. This is

an example of a health need where proper advice is needed; however the need is fulfilled by the individual making the commitment to work hard to return to full strength. Schmidtz argues that showing children how to take responsibility is crucial, so that they can aspire to be responsible adults who value the achievement of taking care of themselves and not expecting others to care for their responsibilities:

“In the long run, though, what our children may need (more than guaranteed income, more than vitamins, more than vaccinations, indeed more than anything) is to live in a culture that fosters excellence, a culture where high achievers continually invent better ways to meet whatever needs – vitamins, vaccinations, whatever – their fellow citizens may have” (Schmidtz D. , 2006, p. 169).

This is especially true in the case of health as many habits that affect health such as diet and exercise are entrenched in childhood and adolescence.

For need-claims, including need-claims in health, there must be a suitably narrow conception of needs that are distributed. The conception must include considerations of what can be done, what resources are available to meet the needs, and whether meeting those needs conflicts with other important goals of society. Meeting needs is not just about material goods. We also need values. Schmidtz argues that we need a culture of personal responsibility in which society asks, “... whether people do something to deserve what they get” (Schmidtz D. , 2006, p. 178). What we also need, according to Schmidtz, is the ability to know what we expect from each other. We need to be able to rely on the fact that those who are in a certain position will behave in certain way. We need to be able to expect that health professions practice according to ethical guidelines (for example).

V. The Three Theories

We have seen now three theories of justice that have been applied in the context of health. We have seen Daniels' extension of Rawls to health, a luck egalitarian justification of health, and my use of Schmitdz's pluralistic theory that I argued could be used to justify some minimal right to some health care entitlements. We have seen that all three theories have substantial grey areas which at first do not seem to tell us a whole lot about what we could expect in a real world health system based on any of the theories. I will examine how each theory can be applied to a real world context. In order to do this I will compare each theory in terms of a right to health, specific health entitlements, health promotion, and regulation of behaviour. This will clarify the theories of justice as they would affect real life policy decisions about the provision of health and health care.

a. What We Owe Each Other

In this section I examine the validity of each theory's justification for a right to health. I will ask what a right to health really means and whether it is something that should be enshrined in law.

For Segall, the primary aim of justice is to promote and protect equality of welfare. So when we ask if we owe each other a right to health, Segall's theory says, yes there is a right to health based on the luck egalitarian view that justice requires equality of welfare supplemented by a presupposition that we must meet basic health needs including basic health needs. Segall's argument depends on a premise that is only acceptable to a welfarist luck egalitarian who accepts that equality of welfare is the aim of justice. Segall's argument is unconvincing because equality of welfare is not the primary aim of justice, and it is too broad a statement to be able to usefully apply in the context of health. It does not set proper limits as to what we owe each other, and his theory says that all aspects of life that affect health are covered. It does not adequately consider also the consequences of resource constraints to a right to health. We cannot provide everything to everybody and yet according to Segall, justice requires us to essentially cover not just health care services but also to ensure that the social determinants of health are covered by this theory and therefore should be covered by society. If it is only possible to cover these things in an ideal setting then one has to ask whether there is any real world health care system that could possibly be just.

A further requirement on a right to health under Segall is that people must be compensated for the bad brute luck that they suffer from. I find this aspect of luck egalitarianism unsettling as a conception of justice as it is too worried about comparing people's inferiorities. I argue, along the lines of Schmitdz and Elizabeth Anderson, that compensating and comparing so called inferiorities is

degrading, does not promote equal treatment of individuals, and abandons those who suffer from mistakes they have made to their unhappy fates. We saw that the only way Segall can get around the abandonment objection is to presuppose that we as a society owe each other basic needs including health needs which he does not clearly define. Segall's answer to the fundamental question of justice then as I interpret it, is that we owe each other the basic resources in life to secure equality of welfare, and in the context of health we not only owe each other access to fulfil our basic health needs, but also we owe each other access and provision to certain goods and services that influence and can determine the state of one's health, and divvying up resources is dependant on what we define (as a society) to be bad option or brute luck.

I argue using Schmitz that health in general is not a right if we have a right to negative liberty (being free from interference from others). Health in this sense is a right in that we have the right for our health not to be harmed by other's actions. It follows from this then that health entitlements cannot be a given, but measures that protect people's health from external threats. One example of this could be regulation in workplaces that protects workers from threats to their health from their working conditions. Aspects of health in certain contexts are something that should be protected and promoted depending on the situation and depending on the principle of justice that is used. Determining what principle can and should be used is not straightforward as Schmitz acknowledges (Schmitz D. , 2006). If it is up to our own judgements what principle should be used, then we have to take in to account other considerations outside the scope of justice. We should protect the health of our children, for example, based on the principle of desert in its promissory sense. That is, children deserve (and we owe them) the chance to be healthy; the chance to grow up and be healthy adults. Beyond the principle of desert we would also have to find a reason outside of the scope of justice in order to strengthen the argument as to why we might prioritise the health of our children. This might be for economic reasons, for example, that we believe that society will be more productive the healthier the next generation is. There are a variety of ways that this can be done: through schools and as a part of the routine way that society intervenes to protect children from troubled homes. For example it makes sense that a government department such as Child Youth and Family (CYFs) ensure that when they intervene that children are in healthy environments. Ensure that foster parents are required to serve healthy food, and when intervening in high risk families, that the health of the children- not just the physical safety - is promoted. Even in cases where government intervention might be justified using Schmitz's theory, there is no guarantee that governments will be effective at promoting health and providing efficacious health care services. This truism reminds us that in a case where we as a society believe that we owe each other a level of care, that it is not enough to

simply start a program to address it. We should go even further than this and say that if we as a society choose to provide a service as a matter of justice, that we have a duty to each other that the service we provide is of a high quality. Even with high quality services we will run in to problems however, as James Wilson points out, because programs that are designed to have life changing results for a large amount of people rarely work:

“Efforts to do this on a large scale and by bureaucratic processes have not, on the whole, proven very successful. Though here and there one can find promising projects, most efforts to rehabilitate large numbers of delinquents or criminals have met with more failures than successes” (Wilson, 1994).

Wilson concludes that the way we are raised, or ‘habituated’ will be more important than intervention by government, and more important than the incentives and disincentives put in place. Whatever balance of incentives/disincentives we have, they are not alone going to achieve sensational results. Individuals still have to choose to take advantage of the incentives that are available. What will really make the difference to health is a change in culture (which is aided by government incentives) where individuals choose to live differently by viewing their health as something that they are responsible for and can change for the better to benefit not only themselves, but also the health of their families.

We must look at the question of whether or not we have a right to health in the same way that Schmidtz approaches justice. Health is a complex issue as one’s health depends on so many variables. One’s genes, one’s environment, lifestyle, family background (or as Wilson describes it, habituation), and the quality and availability of medical services all affect one’s health. Therefore we must tackle health, not from one theoretical angle, but from the perspective of each individual and realize that each issue could require a different element or combination of elements to decide what principle of justice is best applied.

Another application of Schmidtz’s theory relates to the context of need and whether providing health care services is an appropriate way to meet those needs. One can argue that some kind of right to access health services and possibly to some of the determinants of health can be justified by the principle of need. This might be covered by regulations to enforce housing codes, to make sure that rental properties have proper insulation and heating for example. It might also mean that we as a society fund free medical and dental clinics to provide basic health services to the least well off in society. In the context of health, the nature of different health needs may determine what kind of policy is implemented. For example, vaccinations are an effective way of preventing the spread of

infectious diseases. We still have to ask ourselves whether short term, one-off health measures are the best ways to meet needs and should be viewed as secondary to other measures.

We have seen already that Schmidtz is not concerned with equality of opportunity as Daniels says, he is instead concerned with improving opportunities - not simply in comparison with others. The principle of equality à la Schmidtz could be used to justify in what situation health is something that we should be promoting and protecting, as his principle is based on equal respect and an extra consideration beyond the scope of justice: humanitarian concerns for suffering. This is pretty much the opposite view of Daniels in his argument.

Daniels argues that there is a right to health because health affects our opportunities. The focus is on the importance of maintaining normal species functioning in order to promote equality of opportunity. Having opportunity available to us is an important value for justice, and not just because it helps us to have good jobs. It allows us to not only pursue career goals, but gives us the opportunity to pursue activities that we love and to be a functioning member of political and social communities. Daniels concedes that there has to be a limit to this right because we have other important social goals and values as well as resource constraints. He also concedes that we have to consider Rawls's first principle of equal basic liberties while applying the second principle of equality of opportunity and the difference principle. The primary aim of justice in this view is to promote equality of opportunities with the first principle used as a check on how far the second principle can be applied. Daniels also has a broad understanding of what health is that he thinks should be universally applied. We have to have a fair and open process to determine the boundaries of the right to health, according to Daniels.

We have to ask Daniels' theory then whether the principle of equality of opportunity should be used to enshrine health as a right in law? Should a right to health be added to a bill of rights type document? In my view Daniels' and Segall's theories support the enactment of legislation to guarantee health entitlements based on a right to health. A right to health would not necessarily have to be added in to a constitutional document for this to happen, but if this could be done it would make laws that protect entitlements and government policies backed by a constitutional right rather than a philosophical and political argument that could rapidly change back and forth to various degrees depending on the government in power. This might promote stability in the health sector. However, this cannot be done as the definition of 'health' varies greatly and enshrining 'health' as a right in law has the danger of being too ambiguous to be useful in a legal sense in the same way that the term 'freedom' on its own is too vague to be used on its own. For example, in the US

Constitution, citizens are not guaranteed ‘freedom’ in general. The constitution specifies a right to free speech, a right to free assembly, and so on. Defining health and therefore what health needs there are varies in clinical circles as well as in philosophical circles. Some definitions of health are concerned with the value or desirability of health, while others are concerned with treatable conditions, statistical normality, pain and suffering, disability, homeostasis, and so on. Even a relatively uncontroversial definition of health: “...normal functioning, where the normality is statistical and the functions biological” (Boorse, 1977, p. 542) does not include normal functions that require medical intervention such as pregnancy and childbirth (this point has been made by Daniels, Segall, and Boorse).

While Daniels argues for a moral right to health, he is not trying to argue that health entitlements are automatic. He argues that his account of a right to health based on the fair equality of opportunity and normal species functioning is specific to a society, so the entitlements and how one determines what a right to health means is relative (Daniels, 2008, pp. 316-317). This is in contrast to Segall who argues that his theory can be applied internationally and is not culturally relative.

If a right to health is put in to law it is best done therefore by specific legislation that covers certain aspects of health, such as a right to a treatment in an emergency room, or the right of children to receive basic dental treatments, and so on. The fact that ‘health’ in general cannot be straightforwardly talked about as a theoretical concept and, even more importantly, put in to law, further supports my contention that it is more appropriate to look at health issues independently to decide what principle of justice might apply and what society may or may not owe individuals.

b. The Extent of Entitlements

In this section I will discuss whether the theories’ justifications for a right to health ultimately and logically result in provision of universal health care entitlements. I will argue that in practice Segall and Daniels’ theories would lead to similar results in the number and nature of entitlements given even though they approach a right to health from a different angle. However different their approaches they share a common view in justifying health care and health related entitlements. This is that they start from the assumption that universal entitlements are the ideal, and work backward from this to decide how restricting certain entitlements that we cannot afford can be justified. What is different is the way in which they work backwards. Using Schmdtz’s theory however, I start off with the assumption that universal health entitlements are not the ideal (the ideal being that

government intervention is not necessary) and from there work to justify government intervention in health based on one or more principle of justice.

i. Segall and Entitlements

Segall argues for broad sweeping universal health care entitlements that are deigned to cover everyone and most conditions with the caveat that those who engage in risky behaviours can be justifiably made to contribute more (this refers to the compulsory insurance scheme discussed in previous sections). This allowance is designed to address the bad option luck but also cover those who suffer from brute luck. The purpose of health entitlements is to promote equal opportunity for welfare. Furthermore Segall says that the most just way to provide health care services is on the national level, and that distribution should be based on medical need rather than cultural needs or preferences. According to Segall, the more, "...accurately the health care system responds to the medical needs of the population it serves, the more just it is" (2010, p. 141). In opposition to Segall's theory of justice and health are the ideas put forward by Elizabeth Anderson which I have previously mentioned are closely aligned with Schmitdz in his version of the principle of equality. Anderson's theory of democratic equality is concerned with securing freedom by refraining to tell people how to use their opportunities, not judging how responsible people are for their choices that lead to bad outcomes. Anderson's view is appealing because it also focuses on and avoids the depletion of society's scarce resources by setting a limit to the range of goods that are provided. It also suggests the establishment of expectations that individuals can and will take responsibility for their lives.

One could argue that a basic level of health care is important to this theory so that individuals are able to participate in political and civil society. Unlike luck egalitarianism, it is not the aim of a theory of just distribution to tell citizens how they should live in order to make the most of their opportunities or to judge how responsible people are for the choices they make. Anderson instead claims that distribution of collective resources can avoid the unsustainable consequences of providing for those who are imprudent, by setting a limit on the range of goods that are provided for by society, and institutionalising an expectation that individuals take personal responsibility for everything else. Because Segall is arguing from a welfarist version of luck egalitarianism, he argues for a universal health system that is in-kind. Segall wants to say that his account will not succumb to the Stradivarius objection, which is the objection of someone who for some reason needs an operation to allow him to walk again. But instead of walking again, this person who is a keen violinist would prefer that the money spent on helping him to walk again would be better spent on

buying him a Stradivarius as this would give him more job opportunities in life than walking alone would. Segall says that Daniels would fall prey to this objection as some patients could claim that a cash payout rather than medical treatment would serve them better. I am not sure if this is a fair criticism of Daniels' theory, however, as Daniels is concerned with restoring normal species functioning in his theory, not simply the expansion of opportunities. Segall says that luck egalitarianism can respond to the Stradivarius objection because of our duty to meet basic needs, not give cash payouts to those who don't want their basic needs met, furthermore, as luck egalitarianism is concerned with fixing or at least neutralizing the inequalities caused by bad luck, those who are ill because of bad luck should be entitled to medical treatment to reverse this bad luck. The only time that a cash payout would be acceptable in health is when medical treatment cannot reverse the tide of negative consequences resulting from a person's bad luck (Segall, 2010, pp. 84-86). Anderson sees the compensation to individuals for their bad luck as morally dubious as we have already seen. Segall on the other hand argues against Anderson's own views on equality and says that they are not fitting for health.

Andersons' theory of justice as democratic equality, according to Segall, is a reaction to luck egalitarianism to show that justice only requires that we equally distribute those goods that are needed in order to make sure that citizens are capable of acting as equal citizens and "...Whatever capabilities are necessary to enable individuals to avoid or escape entanglement in oppressive social relationships" (2010, p. 37). Democratic equality is not concerned with looking at whether someone's democratic capabilities are threatened by a chance event or by the fault of the patient unlike luck egalitarianism.

Segall has strong objections to applying Anderson's democratic equality theory of justice to the distribution of health care. His first objection is that it does not consider absolute levels of good (Segall, 2010, p. 38). He says that everyone could be equally terribly worse off and in a great amount of pain but as long as you could vote and write a letter to the editor, then a democratic equality proponent would accept this situation as just. This theory he claims is compatible with a very unhealthy population. You can turn this argument against Segall, however, by claiming that luck egalitarianism does not sufficiently look at absolute levels of good.

Another objection Segall gives is that in deciding upon a sufficient level of well-being, we would have to ration treatments in such a way that only those who were barely below the level of sufficiency would be treated, and the very worst off would not receive priority treatment (Segall, 2010, p. 40). There is no evidence, however, that this is necessarily the case. If we are to treat those

who are somewhat worse off but abandon the most poor and most unhealthy, this is not treating the very worst off with equal respect as fellow citizens. I can see no reason that Segall has to assume from Anderson's theory that those who are in desperate need for medical treatment would not be eligible for treatment. Anderson does not talk about different groups of society having a different amount of democratic worth. Furthermore, a theory such as Anderson's might make rationing less common. As there would be a limited range of medical conditions that would receive government funding, there is the possibility that the health budget could be balanced and provide comprehensive care for that limited range. If a government health department is focused on a smaller amount and kinds of medical interventions whether they are preventable or not, there could be more resources and energy spent in ensuring quality and cost effectiveness in providing a smaller number of services. When a health department grows to such a state that it encompasses all medical conditions including enhancements such as male pregnancy it has the great potential, if not the inevitability, to become too unwieldy, too bureaucratic, less reactive to the needs of the population, and less politically accountable for effective outcomes.

Segall's final objection is that democratic equality would not justify treatment of those who were above the sufficient level. For example, if someone was in chronic pain but could still make it to the polling booth, Segall says, "Surely, this does not seem just" (2010, p. 40). While it might be unpleasant for the person in chronic pain, this does not mean that someone with a chronic pain problem would have no resources under democratic equality to receive treatment. A social minimum could include the treatment of these kinds of conditions to be funded by the government. Segall's response that it does not *seem just* is not a very convincing argument. Additionally, accepting the principle of democratic equality does not mean that we have no humanitarian concerns for our fellow citizens. It also does not mean that by arguing against a comprehensive government-run health care system, it considers that there is no way for people to receive affordable health care.

ii. Daniels vs. Segall

Daniels also is an advocate for universal health care entitlements although for different reasons from Segall. His theory is explicitly unconcerned with who is responsible; instead entitlements are designed to promote equality of opportunity. Daniels argues that actual health entitlements that would follow his right to health would still be based on the procedural justice that had the conditions to hold decision makers accountable for the decisions they made about what health entitlements to provide or exclude. The entitlements that follow this process Daniels calls progressive realization. The right to health and health care is "progressively realizable" (2008, p. 318) because decisions

regarding what entitlements are provided are specific to the conditions in a society at any one given time. By arguing that health is a right, Daniels argues, we can try to improve the health of the population (2008, p. 332). The purpose to Daniels argument then is not to argue that we should necessarily guarantee one kind of health system or that governments should provide everything to everyone. He is instead trying to argue a case for broadening the health entitlements that are currently available by giving decision makers a theory to base a right to health, and guidelines for implementing health entitlements so that these entitlements (and cuts to certain entitlements) can be accepted as legitimate. By leaving such a vague description of suitable health entitlements the theory is supposed to be suitable to apply in countries with different economic and social contexts. I would argue, however, that Daniels' theory is not specific enough. Even though he acknowledges that a right to health should have proper limits, his theory is too dependent on the decision makers in various countries to make the right decisions. It also makes the possible range of entitlements described in his theory as too vague. Furthermore, the conditions he places on resource allocation decision makers, in my view, are meant to limit the scope of health care services as per resource constraints and are not designed to ask whether a given health care service is really appropriate to begin with. While both Daniels and Segall have argued for a moral right to health in different ways, how then do their arguments compare in the case for entitlements?

The luck egalitarianism account differs from the Rawlsian account of justice in many ways. Rawls's difference principle does not separate out those who are responsible for what they have and those who are not. Neither does Daniels, in his Rawlsian account of health. Both Segall and Daniels state that in claiming that there is a right to something, you are saying that it is something that cannot justifiably be denied and that must be able to apply to all free and equal persons equally. But the provision of health care will always be unequal as our health needs are unequal whether they are due to a social determinant of health or to a genetic predisposition or mutation. The emphasis for Daniels will then be not on equal shares of health care resources but on equal access to services when they are needed.

Daniels argues against luck egalitarianism on the grounds that it is too expansive because it would cause us to cover enhancements as well as health needs and at the same time be too restrictive (Daniels, 2008, p. 72). It is too restrictive first of all, because it claims that we do not have an obligation to assist people whose unfortunate welfare is a result of bad option luck. We have already seen, however, that Segall has attempted to get around this objection by claiming that we have an obligation as a society to meet basic needs including health needs. However, luck egalitarianism without such a response does indeed leave the abandonment objection unsatisfied. Segall's claim that

we must meet basic needs is rather hollow, however, as he does not justify why meeting all basic needs is important to justice. To be sure, the point of luck egalitarianism is to protect our opportunities for welfare. However, in my view, basing a theory of health on luck egalitarianism, and only really relying on luck egalitarianism when it comes to making the imprudent pay higher taxes to engage in risky behaviours, is not really a theory of health based on luck egalitarianism. Especially since Segall claims that this tax or compulsory insurance on risky behaviours is not mandatory in this theory. It would only be mandatory if real world needs demanded more resources in order to provide universal health care coverage. In my mind Segall would be best served by basing his theory of universal health care coverage on the fact that we have a moral duty to provide for people's basic needs including health, and supplement that theory with luck egalitarianism to be able to meet the objections of those who would object by saying that meeting basic needs does not take in to account personal responsibility and imprudent behaviour.

According to Daniels, luck egalitarianism is at the same time too inclusive to those who are suffering from some kind of disadvantage regardless of whether someone is really ill. This is the same objection that Daniels made to Sen's argument of capabilities. This might include those who would wish to change some aspect to their physicality, but not because it affects their normal species functioning. For example, if one wanted to have a sex change operation, universal coverage might include this kind of procedure as one could argue that one did not have a choice to be born as a certain sex, and therefore worse off because one does not identify with the sex one was born with. But being born as male or female is not only a normal functioning of the human species; it is a vital aspect of the propagation of the human race. This may seem unfortunate or unfair to those who are wishing to change, but justice does not require society to change people's sex. Although it may require society to not discriminate against those who decide to identify with a different sex to the one they were born with. According to luck egalitarianism, Daniels says, "It is not enough to show that one is worse off than others; one has to show that one's best path still makes one worse off than others" (2008, p. 74). In the case of a sex change operation this would mean showing that one is worse off than they would have been if they had been born a different sex. How is it possible to prove that one is worse off than others when there is no objective scale to show that because one was born as a woman and not a man, that person is worse off than someone who was born short and wished that they were taller because they could not feel confident at their given height.

Daniels' expansiveness objection is compelling, because enhancement arguments do not do enough, in my view, to justify universal access to treatments that would enhance a person's height or change someone's sex. The fact that society chooses not to accept a person the way they are means that

society must change the way they perceive and treat that person rather than providing entitlements for that person to change their physicality to match who they feel they are or should be. These kinds of treatment that one could classify as an enhancement rather than a medical treatment of a physical illness is not a compelling argument in the real world where universal health systems struggle to treat those with cancer in a timely manner, and where (as we shall see in the section below on rationing) new and expensive medicines that can save and extend lives are often not funded as they are not cost effective for the population as a whole. Daniels says that Rawls and Daniel's extension of Rawls to health has a baseline that is decided by the natural lottery which is only partially mitigated by the difference principle. The luck egalitarianism appeal to the opportunity for welfare shows that one of the fundamental differences between this theory and the Rawlsian approach is that they disagree on what should count as a deficit in health that society is obligated to treat.

Segall's response to this argument is that yes, there is a moral irrelevance to the difference between treatment and enhancement except in extreme cases such as those who are short. Not only this, but Segall fires back by saying that Daniels' account is too narrow by claiming that he cannot explain medical interventions that are necessary but are not a result of a deviance from normal functioning such as pregnancy, childbirth, and even vaccinations as vaccination is an enhancement as those who are vaccinated are healthy. Daniels responds to this criticism by saying that promoting health by means such as vaccination is promoting normal health functioning as it is preventing people from deviating from normal functioning. Thus, vaccinations are enhancements not normal functioning (Daniels, 2008, p. 154). Segall's response to the sex change argument shows that Daniels' critique that luck egalitarianism is too expansive is right on the mark: "...the luck egalitarian view recommends funding sex change operations for anyone who thinks the male or female body is an unfortunate mistake...it constitutes a disadvantage to have a body of the wrong sex when most other people are able to enjoy a body of the correct sex. And if some men really wanted to, we ought to make it possible for them to get pregnant, or alternatively compensate them for their inability to do so" (2010, p. 131). This seems to be a stunning contradiction for Segall to claim that men who want to be pregnant deserve some kind of compensation, as he has claimed that luck egalitarianism is able to overcome the Stradivarius objection. How can we say that swaying the tide of fortune to unhappy non-pregnant men by compensating them in some way is treating them in kind? How would we compensate them? Would a cash payout do? What were to happen if after the man became pregnant he decided that actually he would be better off to get an abortion- would we owe him that as well?

While Segall admits that, "...given budgetary constraints these medical procedures may not be very high on our health agenda, but that does not mean that funding them is not a requirement of justice"

(2010, p. 133). I would ask where this kind of example fits in to Segall's theory of health care? Not only is helping men to get pregnant not classifiable as a basic health need, this theory leaves no room for individual responsibility. Responsibility cannot be so narrowly defined that the only aspect of responsibility that matters is what we are *not* responsible for by defining it only as what we did not choose. There are many instances in life where most people would consider that they are responsible for even if they did not choose the circumstance.

I have considered two objections to the luck egalitarian account of health care entitlements, but it is now time to consider Segall's criticisms of Daniels. Because Daniels says that a right to health is based on the moral importance that health has because of its effect on opportunity, Daniels theory could be used to justify selective health care. This is a weakness that Segall picks up on. For Segall, equality of opportunity is too narrow a focus of justice and in the case of health it would not cover certain groups. For example, since those with disabilities have fewer opportunities to pursue their life plans then we would only be justified in providing health care to those with disabilities. Daniels on the other hand argues that his theory in reality is much more inclusive in this sense than luck egalitarianism, because his theory does not focus on personal responsibility for health. Daniels rightly claims that determining who receives what treatment by looking at the motivations for someone's actions and whether a consequence was caused by bad luck or a bad choice is too complicated to use as a policy in the real world. Whatever caused one's ill health, Daniels says, the severity of one's health need is more important than if one is responsible for it or not.

Segall's second objection is that most people who need health care are elderly and a large proportion of health care spending is allocated to them (2010, p. 35). The problem is that if we are trying to maximise opportunity, then treating those who are close to their death does not succeed in doing this and instead health resources are used on alleviating pain and prolonging the inevitable. We should either conclude that Daniels' answer to his first focal question is incorrect or our practice of allocating large amounts of resources to those at the end of their lives is incorrect. It is not clear however whether Segall's criticism has much bite as Daniels' theory is flexible enough to include treating the elderly and those close to death as long as this decision is made by a fair and just process. Segall argues that even with this kind of response Daniels' theory is open to criticism because it fails to justify any health care to patients over seventy-four. The provision of health care to those who have already completed their life plans must have some other rationale than what Daniels has offered. However Daniels can also respond to this criticism by saying that part of the normal opportunity range as he defines it is not just about maximising opportunities for career it is also

about our ability to function as free and equal citizens; a point he picks up from Elizabeth Anderson (Daniels, 2008, p. 77).

But couldn't we argue that the elderly have life plans? Their life plan may not be skydiving or working at a demanding job, but it may be spending time with their grandchildren, travelling, or enjoying their retirement in peace. It is an insult to say to an entire segment of the population that their life plans are not worthy of living, and therefore if resources are tight, their treatments will be the first to be rationed. If we say that one part of the population's life plans are worth less than another's and therefore will have a low priority for receiving treatment, then we have also got to ask who will be making this decision? Denying treatment based on the ability to defend how worthwhile one's future life plans are lacks basic respect and dignity for human life. After all, although we may be able to quantify how many health resources are used treating the elderly, how can we quantify what elderly people in our community give back in the present, what they could contribute to others in the future, and to what degree they contributed to society in the past? It is hard to imagine saying to elderly war veterans that since they have very little time left on earth and their life plans are not as full with potential as the younger generations, their medical treatments will be rationed accordingly. This kind of intuition would seem to back Segall's argument that life plans as understood by Daniels do not include those of the elderly.

The reason that Segall can argue that Daniels' definition of life plans is not broad enough is that the whole principle of free equality of opportunity comes from Rawls who uses this principle in his theory to talk about career and job prospects, and the rewards that come from them. Segall argues that extending this theory out to life plans in general beyond those of careers and the benefits of a fruitful career is flawed: "Even the provision of aspiring to individuals who can be said to have completed their life plans must, if we hold Daniels to his theory, be justified on grounds other than opportunity to pursue life plans, and therefore other than justice. That seems problematic" (Segall, 2010, p. 33). This is not a convincing argument from Segall however as he also appeals to other notions outside of his main theory to justify the use of luck egalitarianism as a theory for the distribution of health. He argues that Daniels' theory does not allow us to distribute as equally as luck egalitarianism would like. This is because the equality of opportunity is in the context of careers between people who are of equal talent, so that there are not social barriers to a successful career, and is not designed to correct the genetic lottery of disease. This cannot be extended successfully though to a broad definition of life plans as talent and ability quite often have no link to one's health, and perhaps in the case of the elderly, health has a very tenuous link to their life plans.

Another objection is whether or not this fair equality of opportunity really justifies universal access to health care services and a right to health as he defines it. Daniels in my view does not justify access to universal health care, because of his emphasis on fair equality of opportunity at the cost of the lexically superior first principle of Rawls. According to Schmitdz's interpretation, Rawls did not intend to place an inordinate burden on society so that we place an incredible burden on the well off that will tempt them to emigrate from the country, only to provide very small benefits for the worst off. Additionally, the difference principle is only meant to apply to the institutions of society that make up its overall structure. It is not meant to be used on a case by case basis which is perhaps why Rawls does not mention whether those in the original position were healthy or not. Crucially, though, Schmitdz very wisely points out that the difference principle is not meant to be used in such a way that it could harm the least advantaged, which could be the case if the burden we placed on the wealthy was so great that they would rather move than have a large percentage of their income taxed. This restraint on the difference principle includes institutions that "...overzealously apply the difference principle to the detriment of the least advantaged" (2006, p. 190). An example in health is the ever increasing number of New Zealand trained doctors who leave the country once they have finished their training as there is a significant pay increase if one works in Australia or the UK compared to working in New Zealand hospitals. While doctors are certainly well off in comparison to most people and especially to the worst off, by not properly recognising their skills and knowledge sufficiently with comparable income rates and working conditions of other countries, we are certainly taking from the better off at the detriment of the worst off and the country as a whole. In fact the New Zealand government careers website cites the reason that there is such a shortage of doctors is that a large percentage of New Zealand trained health professionals move overseas for "better pay and working conditions" and this trend is not new:

"A review of graduate retention statistics since the introduction of the Medical Practitioners Act in 1995 shows that by the third year after graduation, about 25% of doctors trained in New Zealand are practising overseas. This figure has remained almost constant from 1998 to 2006" (Services, 2009)

The current National government has introduced a bonding scheme in order to staff urgent regional and vocational vacancies. It is too soon though to say for certain whether this has changed this trend.

iii. Schmitdz and Entitlements

I said at the beginning of section b. that the primary difference between the arguments of Segall and Daniels and my use of Schmitdz is that Segall and Daniels start to form a position that assumes extensive coverage is the ideal and then focus on how to limit coverage. Whereas I believe the question is how we can justify expanding the number and kinds of entitlements.

Schmidtz's pluralistic theory allows for provision of health to be justified by a number of different principles of justice, although it does not justify universal health care systems per se. However, even a pluralistic theory of health will have to admit defeat when it comes to the reality of scarce resources and the reality of rationing. A 'right' to health will always be incomplete and partially covered at best as we still have to decide how we distribute resources that contribute to our health – whether that is health care services, education, or laws that must be enforced to protect public health. It is my contention in this paper that a right to health not properly defined will result in a costly system, with an unjustifiable interference from governments and insurance companies in the way we live our lives, and/or a system that tightly rations what services and resources are available.

What we must aim for is to have efficient and high quality services that will cover the basic health needs of all people so that they can participate in civil society as free and equal citizens. I believe that this will mean that the following services and policies should be provided (this is not a complete list necessarily, only examples of what a basic minimum should include):

- Emergency care
- Addiction clinics
- Vaccinations for infectious disease
- Health education in schools
- Programs for children from low income families that could include but are not restricted to: dental, nutrition, and health education.

The services in the above list can be justified using Schmidtz's principles of justice. Perhaps one way of doing this is to look at the order in which we might use the principles. The first principle that we should turn to is need. If the principle of need doesn't fit, however, or there are problems in implementing a program or law as it violates a different principle of justice, the next principle that we should turn to is the principle of desert. The principles of equality and reciprocity could potentially be used to justify a health entitlement, but are really more fitting to be used as principles to guide how health care services are distributed.

The principle of need should be used first, as the term can be associated with life and death and debilitating conditions in the context of health. Victims of car crashes will need emergency care, and a humane society will work to address that need by ways of ambulance services and hospital emergency departments. Of course emergency care is not the only way we can address the problem of people getting injured in car crashes (speed limits, drink driving laws, and driver's licences are ways that we try to prevent car accidents). Programs for children from low income families can also fit under the umbrella of need as their parents may not have the available resources to pay for basic

medical care. This may be a need but it also overlaps nicely with the principle of desert, as we could argue that children should be given the best start in life possible. If they are not given the best of starts from their caregivers, then we as a society can still give them the opportunity to be healthy.

Another example of a situation where the principle of need and desert overlap in health is in the health problem of addiction. Addictions can be devastating to one's physical and mental health, and to that of the family, especially if a person's addiction is not allowing a person to take responsibility for their life because one cannot hold down a job. This is further exacerbated because available resources are diverted to support one's habit instead of using it to better one's life situation and the situation of one's family. If an addiction is preventing someone from employment, causing mental and physical ill health and puts that person and others in dangerous positions, one can argue that there is a need for intervention. But we can also justify a social minimum that includes addiction clinics for those suffering from alcohol and substance abuse from the principle of reciprocity in its promissory sense. Addictions are near impossible for individuals to fight on their own. A well designed and effective service for helping those with addictions is essential to give those with addictions a chance to have a better life. It is not only those suffering from addiction that can have a chance at a more promising and fulfilling life, but also the children and other family members who are affected by the addiction of their loved ones. I have also included health education in schools in the above list as a principle of desert (in the promissory sense). Using the principle of desert, I argue that health education is an important way in which we can teach children the knowledge and skills to make healthy lifestyle choices as adults.

I have stated above that the principle of equality could also be used to justify some health programs in so far as equality is about equal treatment. But perhaps instead of using the principle of equality to guarantee one kind of health care service, the principle of equality in the context of health care distribution should be focused on how programs are implemented rather than what programs are implemented. The focus of departments or public/private partnerships that are responsible for the provision of health care services should be about access, quality, and effectiveness rather than on equality. The programs are not justified by comparing the status of some groups with others, worries over inequalities, they should be about providing quality services in order to improve and maintain the health of those who need it rather than compensating some groups for the bad luck they may have suffered. I have argued for the above list as these are all health needs that can be addressed by distributing resources to pay for health care services that will meet these needs as per Schmidtz's principle of need distribution. They are also valid services as they appeal to our concerns to be

treated with equal respect and dignity by not allowing those who cannot afford care to die on the streets, and those who cannot afford medication to live with a poor quality of life. Vaccinations are probably the most egalitarian as they are designed to protect the entire population from disease.

A problem that arises from justifying health entitlements based on only one right to health is that often programs have negative unintended consequences. It is better, in my view, for a health program to be justified by more than one principle. My example of addiction above showed that addiction clinics could be justified by the principle of need and the principle of reciprocity. An example of the problem of unintended consequences in New Zealand is how the introduction of the HPV vaccine (brand name Gardasil used to reduce the risk of developing cervical cancer and certain vaginal and vulval cancers that are caused by the Human Papillomavirus) took a political turn. A relatively low number of women in New Zealand develop cervical cancer each year as, “In 2005, cancer of the cervix uteri accounted for 1.7 percent of female registrations and 1.4 percent (54) of female cancer deaths” (Ministry of Health, 2008b). This disease disproportionately affects Māori and Pacific groups which is seen by some as one of the primary reasons that Gardasil was approved for funding. There was considerable political pressure put on the government by the makers of the vaccine as well as some special interest groups to fund this vaccine which is why funding was approved in 2008 by then Prime Minister Helen Clark. Funding for vaccines in New Zealand is not regulated by PHARMAC, instead funding comes from the National Immunisation Program. Many are sceptical about the effectiveness of this vaccine and the legitimacy of the process to approve the funding. First of all, some say that there is not enough evidence as to the long-term benefits of the vaccination programs (Zealand, 2009), and there are concerns about the safety of the vaccine and its side-effects, and one can argue the possibility that those who receive the vaccine will be more promiscuous and will avoid regular cervical smear tests. It is too soon to say whether any of these fears will eventuate in to a public health crisis, however the unintended consequences and ways of mitigating them should have been thoroughly examined before the vaccine was approved for funding and campaigns to vaccinate initiated.

The unintended consequences of this vaccine include whether this vaccine will really be effective in minimising the rate of cervical cancer caused by HPV. This is another element that needs to be addressed when governments create programs in the name of public health. The costs to society economically and otherwise must be justified by how effective the program is going to be. This means that among other things there must be an adequate amount of resources given to programs in order that they have a chance to be effective. There are many beneficial public health programs that

have been shown to improve the health of populations in huge ways. The most obvious of these is vaccination against smallpox which was eradicated in the 1970s. The WHO spearheaded the global effort to eliminate smallpox worldwide:

“In 1977, the last case of smallpox was reported in Somalia. For the first time, a major disease has been completely vanquished. Dr H. Mahler, WHO director-general, described the smallpox program as "a triumph of management, not of medicine." It is said that at a meeting in Kenya in 1978 the then director-general, on announcing the end of smallpox, had turned to Donald Henderson who had directed the smallpox program, and asked him which was the next disease to be eradicated. Henderson reached for the microphone and said that the next disease that needs to be eradicated is bad management (Hopkins 1989).”
(<http://choo.fis.utoronto.ca/fis/courses/lis2102/ko.who.case.html>)

This is a case where a public health program was effective, as resources as well as medical knowledge and effective management, met to eradicate a highly contagious and deadly disease.

Another benefit of public health initiatives is that they can increase general awareness and understanding of diseases, and with this comes a certain amount of normalisation and social understanding. Awareness of diseases leads to more people being screened earlier for disease which is crucial for survival for illnesses such as cancer where early detection can save lives. Awareness also brings about normalisation for mental illnesses, where depression for example, is seen to be a legitimate condition that can be taken seriously and dealt with so that those with these conditions do not feel helpless and are not afraid to seek treatment and support. Seeking support and help to deal with one's illness is a way that individuals can take responsibility for their health and having services that spread knowledge about the nature of these diseases and who can support people with them is a way that we as a society can assist those affected in feeling empowered, despite whatever illness they may have.

If there is no way that a program can be funded at the level which it needs to be effective then we have to seriously question whether it is worth the cost of setting it up at all. This is not to say that we should only have programs that we can throw huge amounts of money towards. Cost effectiveness of programs and subsidies are essential. Money is not the only aspect of an organisation that is crucial to effectiveness. The right people must be hired, and programs must be based on the latest scientific evidence. I will speak more about these requirements in my concluding arguments.

Providing basic medical care is not the only way that principles of justice require us to intervene in health. We also need to have sensible laws to minimize health needs in society without stepping on the individual liberties and freedoms we enjoy in democratic societies. We need laws that will ensure the right to privacy and informed consent, and regulation regarding the safety and

effectiveness of medicines for example. With laws that regulate aspects of our health we must realise what we are getting in to.

Regulation is a commitment over and above provision of services. The wider the scope of the government in the distribution of health care services, the more regulation is needed. This will also be the case in regards to private provision of health though not to the same degree. Distribution and access to health care services are not the only regulation that is applicable to health. All kinds of regulation can be cited as examples that affect our health; from road safety rules, classification of substances so that they are controlled and (theoretically) are not accessible to the general public, workplace safety requirements, and so on. Regulation is a costly effort and raises alarm bells to libertarian concerns of paternalism in some instances where individuals are protected despite the fact that they may not want to be protected from what they are being protected against. Legislation to classify and restrict medicines and legislation that governs the rights and responsibilities of health providers and health professionals is a complicated exercise that involves an array of agencies each with different priorities. I will give the example of the complexity in one part of the New Zealand regulatory setting which I argue leaves the system vulnerable to abuse, creates inefficiencies, and is costly to maintain, and still leaves the public susceptible to harm.

VI. What Will We Give Up? Limits to a Right to Health

According to Charles Fried, if we are going to claim that there is a right to health, and a right to receive health care, this does not mean that there is a right to equal access to this health care or that there is a right that whatever is available is going to be available to everyone. All those who claim that there is such a right to equal access of health care are merely arguing a slogan which could only become a reality if we submit to "...intolerable government controls of medical practice or to a thoroughly unreasonable burden of expense" (Fried, p. 29). Is Fried right? Part VI will examine the realities of implementing and running governmentally run health care to try and apply the three theories that I have examined. I will argue that there must be stringent safeguards as to what kinds of government interventions are allowable in order to protect citizens from paternalistic policies that are justified for the sake of the greater good. This may seem like a paradoxical statement, but when paternalistic policies restrict freedom to an unwarranted degree we have to ask if paternalistic policies are really worth the potential of oppression. I will ask whether a right to health imposes unreasonable restrictions on our ability to choose our own lifestyle, by means of taxation and education, including those groups that are targeted as especially needy of governmental intervention. Then I will look at the inevitable reality of rationing and how the theories of Daniels, Segall, and Schmidtz can cope with this reality. Implementing a universal and government run health system is not cheap and not without its pitfalls. I will argue that we must decide what we are willing to sacrifice in order to pay for their existence: a large amount of regulation on the distribution and priorities of health (we must accept the prevailing whim of what diseases are seen as more important to treat), threats to individual freedom, curtailment of treatments that can be offered, and a high level of taxation.

In this section I will examine two limits to a right to health. These limits are related to my previous objections to a right to health but are limits that are more practical rather than theoretical. The first limit I will call the stigma objection. This objection says that in an effort to promote health, individual responsibility can be misconstrued or implemented in such a way that those with health problems can be stigmatised and or at the very extreme end of the spectrum, cruelly and unethically, or can be termed victim blaming. Consequences that arise because of well-intentioned health promotion programs that have scientific and medical justifications could be seen as justifiable by some if they have lead to better health outcomes. But there are further problems than just the stigmatisation of certain groups as a result of the state becoming responsible for the health and well being of its population. The second limit to a right to health is the real world problem of rationing.

a. The Stigma Objection

Life is meant to be enjoyed, and each one of us in the end is still able in our country to steer his vessel to his own port of desire. But the costs of individual irresponsibility in health have now become prohibitive. The choice is individual responsibility or social failure. Responsibility and duty must gain some degree of parity with right and freedom (Knowles, 1978, p. 38).

This section will look at the consequences of universal health care systems on the freedom of the individual. I will argue that the combination of universal health care systems and the freedom of individuals not to take care of their own health results in social stigma against the unhealthy who are perceived to be irresponsible. It is inevitable in a culture where people expect to be taken care of that rather than taking care of oneself, that individual responsibility is viewed negatively as blame rather than as self empowerment. Taylor & Hawley use Isaiah Berlin's distinction between negative and positive freedom in order to discuss the best way for governments to promote the health of their population without the worrying implications of paternalism. They claim that by following strictly the negative freedom doctrine, which claims that we should be free from interference so that we can act without being stopped or coerced by others (Taylor, 2006, p. 18), we would be "... heartless at best and would neglect to give due weight to the importance of individual health for the general health of society." (2006, p. 16). However, I would argue that following the negative freedom does not mean that we have to be neglectful of others, and that by promoting negative freedom in conjunction with a positive view on individual responsibility that focuses on empowerment rather than blame, that health will inevitably be promoted without unjustifiably restricting lifestyle choices. Philosophers such as John Stuart Mill have argued that community interference in the behavioural choices of an individual is only valid to prevent that person harming others. However, the fact of the matter is that when health care services are provided by the government who are funded by the general community, a person whose individual lifestyle choices are a strain on public resources affects everyone.

If one is to argue that intervention is necessary to address the strain put on the system by some individuals, one can argue one of two ways. One way is to take the stance of negative liberty if the strain put on the system is serious enough that it harms other citizens. If a society's scarce resources (resources refer to more than just money but also availability of quality manpower and so on) are spent on the fallout of drunk driving for example instead of care for premature infants, we could say that constitutes as harm, albeit indirect. This is of course a matter of priorities. Society has to choose what kinds of problems it chooses to allocate resources to. In this case we might say that instead of dealing so much with the fallout of drunk driving we should prioritise the treatment of premature

infants in the national budget. However this is not always plausible as the effects of problem drinking including drink driving are horrific in the loss of life and cause of injury. In order to prioritize neonatal care we might have to stop treating the victims and perpetrators of drunken driving accidents which most societies would reject as inhumane. This does show though that the strain that some put on health systems through preventable behaviours has serious consequences on others. The purely personal matter of a person's (mis)management of their chronic illness harms us all by not allowing public funds to be used on others who could benefit within the health system. It might not just be harming those in the health system, it could also mean that valuable resources that could be spent on other important social goals are stalled or made impossible through the use of resources in the health sector. One could then argue that intervention is necessary on the grounds of negative liberty, that the irresponsible use of one's freedom should not affect the freedom of others, those who make risky lifestyle choices where the consequences require a great amount of public expenditure harm the community in general by not allowing those funds to be spent on other worthwhile ventures, and therefore in these kinds of cases intervention is justified. We have seen that Daniels would have us wear the costs of the bad choices of individuals that result in health needs as his theory is purposely silent on the issue of personal responsibility. Segall would have us treat costs but also impose mandatory health insurance to cover the costs due to bad option luck, and I would argue that some medical treatments are necessary for us to provide, whether or not the individual is responsible for getting themselves in that position or not, if those treatments are a matter of life or death. However if a patient with a chronic health condition refuses to actively participate in their own rehabilitation we still come to the issue of stigma. This is a problem for all three theories.

The second way that intervention can be argued for is through a positive view of freedom. It is certainly true as Taylor and Hawley argue that, "All deterioration in the physical or mental faculties of an individual harms dependants, prevents an individual from contribution to the good of the community, and can create a burden on society... If our actions 'violate' our obligations to others, then these actions are open to censure or 'moral approbation'" (2006, p. 18). Put incredibly simply, positive freedom aims to help people help themselves by limiting the range of bad choices that are available to them in order that they can be better off and free from the consequences of bad choices. Someone looking at health promotion, for example, through a positive freedom lens would argue for greater government oversight of how individuals manage their health. We have to decide as a society whether we give up certain freedoms so that government can have oversight of our health for our own good. If we decide that taking away the choice of getting melanoma is worth it, then instead of

recommendations to wear sunscreen there could in theory be regulation to enforce mandatory sun block when outside.

Proponents of negative liberty would say, however, that being provided unwanted advice and other attempts to control one's behaviour is a threat to the freedom of the individual. I agree that the promotion of health should not take priority over individual liberty, except in cases where it causes real harm to others. When we attempt to limit the freedom of individuals in an attempt to control costs and for an abstract idea of what is good for the community, it is not hard to envision a situation where those in power attempt to impose their values on the rest of society. Those health promoters may have good intentions, but the end products of good intentions are not always worth the cost, as good intentions in certain circumstances can turn from a policy of risk management- which encourages individuals to take responsibility- to a policy of risk control- which encourages blame and censure- and all in the name of public health.

Furthermore certain kinds of health promotion, I would argue, could affect the freedom of some groups over others. Many studies have indicated, for example, that different groups in society have worse life expectancy rates and much higher morbidity rates than other groups as a result of behaviour that is more prevalent in these groups than in the general population. Survey results on the health of Māori and Pacific Island children done by the New Zealand Ministry of Health in 2006 and 2007 found that:

“Māori children were more likely to be exposed to second-hand smoke in the home than non-Māori children (18.9% versus 6.9%). Exposure to second-hand smoke was significantly higher in the most deprived areas than in the least deprived areas for both ethnic groups ... Māori children were also more likely to be obese than non-Māori” (Ministry of Health, 2009).

In this one example we can find that those who favour more paternalistic approaches to health promotion would argue that this ethnic and socio-economic group requires more intervention than other groups, as smoking and obesity are two life-style choices that need to be addressed. One could argue that by intensifying intervention efforts at this one group, means that this group is subject to more control and oversight than other ethnic groups, and is therefore subject to additional blame and stigmas. It is a situation where the values of society and those at the helm of the health care system are imposed on one group of people in the name of health.

One could argue in response, what is so wrong about trying to decrease the inequality between Māori and other ethnic groups by trying to promote good health practice in the Māori community? On the face of it, there is nothing wrong in trying to improve the health of Māori children. What matters in

this situation is not how much intervention is appropriate for the sake of levelling out inequalities between Māori and Pakeha children, but what kinds of intervention are appropriate in improving the health of Māori children as members of our society that deserve equal treatment. If there are differences in the way that Māori are treated in the health system so that they do not receive the same level of care as other ethnic groups then this is of course unjust according to any theory of justice.

The stigma objection is a problem for Daniels, as his account is not focused on personal responsibility there is the danger of backlash and public apathy against those who have medical conditions that cause considerable strain (that many would view as unnecessary) on the health system. It is a problem for Segall as the level of taxation required to overcome the stigma objection would possibly stifle economic growth making it impossible for both the health system and individuals to afford adequate health care. It is a problem for both Daniels and Segall as they both advocate for aggressive health promotion campaigns that have the danger of placing the freedoms that we are used to enjoying in jeopardy for the sake of public health. It is also a problem, finally for my use of Schmitz in health. Using the pluralistic theory which emphasizes the importance and value of personal responsibility in justice could be a fine balancing act at times. I have argued that some health entitlements and health promotion programs could be justified. When and if the health entitlements that are justified under the pluralistic theory cause an inordinate burden on society, there will still be the concern that some groups will be seen as burdening the system too much and be stigmatized for not taking responsibility.

When it comes to health promotion there has to be the right balance between government intervention and personal responsibility especially in universal systems where the cost of treatments are shared by all. If the balance is not right, it could lead to overt government control and the possible stigmatisation of some population groups. The role of government then in health promotion should be to provide reliable information to the public so that they can make free and informed choices, provide efficient and high quality services when warranted, and encourage individual responsibility, and ensure that people's freedoms are not sacrificed in the name of public health.

b. Limitations Imposed by Rationing

“If no one smoked cigarettes or consumed alcohol and everyone exercised regularly, maintained optimal weight... reduced stress by simplifying their lives, obtained adequate rest and recreation, understood the needs of infants and children for nutrition and intellectual and affective nurture... drank fluoridated water, followed the doctor's orders... and used available health services at the appropriate time for screening examinations... the savings to the country would be mammoth in terms of billions of dollars saved, a vast reduction in human misery, and an attendant marked improvement in the quality of life.” (Knowles, 1978, pp. 35-36).

Government health care systems cannot be all to everyone, and are very little to many. Limited resources and an overwhelming demand for health care services have always proven and are continuing to prove a great strain on societies around the world. This section will look at how we can apply principles of justice that have already been outlined previously, to everyday health care rationing decisions. I will ask if the reality of rationing has any bearing on whether or not we can validly say that we have a right to health.

In discussing the reality of rationing, I will endeavour to show what each theory has to say in relation to this challenge, whether the challenge is from a public or private system. I have concluded that Daniels does not sufficiently overcome the challenge of rationing, and that Segall's conception of luck egalitarianism is not particularly adept at meeting this challenge, as he dismisses to some degree the importance of receiving medical services in his emphasis on inequalities in the social determinants of health. I have argued that he still does not escape criticism as many of the social determinants of health are not within the scope of intervention that the government should be involved in. I argue below that the reality of rationing decisions that are polluted by momentary political fervour and marketing campaigns, and the fact that rationing decisions are inevitable, shows that those who argue there is a right to health must be able to show how rationing decisions can possibly be just according to the theories that they propose. I argue that Schmidtz and Anderson escape from the rationing objection relatively unscathed as they do not view health as a right in the same way that Segall and Daniels view it.

Historically, rationing was as simple as the ability of a person to pay for treatment, the availability of health professionals and services in a given area, and the compatibility of the patient to the research needs and practice decisions of doctors. These aspects of rationing are still alive and well today but with an added modern twist. With the introduction of government funded health programs and health

insurance companies, there is a disconnection between the ability to pay for a service and the ability to receive treatment. As a result of this disconnection the demand for health care services has risen faster than any health system has been able to pay for them. Therefore rationing primarily occurs today through administrative decisions made by governments and health insurance providers and through the structure of health systems. The necessity for rationing gives way to what Daniels' calls a problem of legitimacy (Daniels, 2008, p. 103), in which we have to decide what gives decision makers the moral authority to set limits on the availability of medical services and the extent of public health measures. This legitimacy problem is Daniels' third focal question, and I believe the challenge of rationing is one of the strongest objections to the notion of a right to health.

Health systems do not operate in a vacuum and at the end of the day the primary way that we are able to make these decisions is by relying on the normative values that we use in order to justify the existence of the status quo health system. These normative values tell us the trade offs that are acceptable. A review of access to high cost medicines in New Zealand points out this fact to Minister Tony Ryall:

"In theory, if you were to decide to increase government spending on high cost medicines... what spending in other areas of Vote Health would you be willing to cut? Or if Vote Health were to be increased, which other Votes would your Government be willing to decrease? Or would you raise taxes? Clearly such tradeoffs are problematic, particularly given fiscal deficits are forecast for the next five or more years and the New Zealand economy is growing slowly" (Hanse, 31 March 2010, p. 8).

According to A.T. Kearney, furthermore, the future of health care provision does not look rosy as the three current global trends of health care provision are unsustainable to such a degree that Anscombe predicts that there will be an emergence of a common model of health care delivery that will have huge implications and trauma for governments, populations, and health care suppliers such as the pharmaceutical industry (Anscombe, 2008). There is also a global trend of strong population growth in the developing world which includes a growth in the middle classes such as in China and in North Africa which will boost the demand for health care. The third global trend is the ailing state of European models of health care. European countries are faced with ageing populations and declining birth rates: "...by 2020... more than 20% of the population will be 65% or older" (Anscombe, 2008, p. 11). Care for older populations puts a strain on medical resources especially as they try to be universal and fund programs through taxation and mandatory employer contributions to state insurance. There are also projections that the ratio of working people to retired people in 2020 will be only 1.2 to 1 (Anscombe, 2008). This ratio combined with longer life expectancies, better survivability rates from diseases, more expensive medical technologies and the expectations and knowledge of treatments that are available if not funded, are leading to an unsustainable health care

delivery model. Most European systems will now, or in the near future, have to dramatically change the nature of how they provide health care or they will soon face economic crises independent of global economic conditions. They are not alone, as it has also been estimated that China will in 2050 have a similar age profile to Europe. What is left is for governments to make difficult choices, and the options for making systems work are limited at best (Anscombe, 2008, p. 17). These choices are resource allocation decisions, or put simply, rationing decisions.

The consequences of rationing are painful to those that are forced to go without care that could lengthen and improve their quality of life. One could even say that it is especially painful in countries where health care is considered to be a basic human right, and where universal health care is supposedly available, through the use of taxation to run and oversee the provision of health care services. After all, the tax rate does not change depending on whether or not health care services that one may need are available through a public system, and because of this the legitimacy of rationing decisions is even more poignant for public health systems.

Syrett defines rationing as what takes place when, "... an individual is deprived of care which is of benefit in terms of improving health status, or the length and quality of life, and which is desired by the patient..." (Syrett, 2007, p. 19). Therefore, while the rationale of rationing services and treatments may be budgetary, the way rationing decisions are carried out are inherently political decisions, because there will always be some people who are left out. Rationing of health care in modern societies happens through tactics that can either be defined as explicit or implicit. The way in which we choose to ration health care services has the potential to reflect badly on the principle of justice that justifies the provision of that service to begin with.

i. Explicit vs. Implicit.

Explicit rationing is characterised by central decision making either in legislation, or by administrative decisions. These are generally choices regarding what kinds of services will be available, and the criteria for distributing them. Criteria might include who are eligible for different kinds of programs, and what kinds of services, how many will be paid for, and what service providers will be funded to perform the services.

Explicit rationing is a strong threat to the luck egalitarian approach to health. There is the potential in reality that a luck egalitarian based system could discriminate against those who are worse off health-wise because of bad decisions they have made. This would especially be true if the decisions were made explicitly. Segall, as we have seen in previous sections, tries to guard against this by his

idea of the compulsory tax on those who would engage in risky behaviour, and by his requirement that society treats our basic health needs. However, as we are lacking an explicit list of what constitutes a basic health need this requirement is subjective and open to interpretation. Moreover, it would be impossible for society to safeguard against all kinds of risky behaviour in order to tax it. A person might take the risk of cleaning their gutters out, and while climbing up the ladder fall down and break their back, leading to the need for extensive health treatments.

Segall could respond that it is not unreasonable for society to expect someone to climb up a ladder. But what if the person climbing the ladder did not properly secure it, and went out in gale force winds? The point here is that there is no easy way for society to monitor all risks that people take and make sure that they are appropriately taxed in case of future harm. That is unless we raise taxes to such an extent and to a wide variety of, not only activities, but purchases such as ladders that have the potential for someone to harm themselves or others with. At the very least, an implementation of higher taxes to potentially dangerous objects such as tools (which are necessary and useful) would put more than a few people out of business. It would also be a logistical nightmare, and places in the hand of the state and those in the media and general public the ability to judge, condemn, and marginalize those who have made mistakes (as per my stigma objection).

Explicit resource allocation decisions fit well with Daniels' theory, however as his requirements for rationing are that there is an open, debatable, and fair process. In other words, Daniels is calling for an explicit democratic decision making process. Segall's theory cannot fit with this model in my view as it creates a never ending need to impose taxes, a costly and intrusive regulatory system to oversee these taxes are enforced, and marginalizes people for taking risks which would result in a society that could be described as stifling at best and paternalistic at worst.

Implicit rationing on the other hand is characterised by rationing decisions made by clinicians at the patient level, as service providers and practitioners make treatment decisions based on expenditure and personnel constraints. Those who argue for implicit rationing such as David Mechanic claim that the individual doctor is in the best position to make rationing judgments: "The provision of medical care is an individualized and personal process. Much of the value derived from such services is dependent on the trust that evolves between patient and physician, and the ability of the health professional to assess, treat, and support the patient in a manner tailored to his or her personal circumstances, medical characteristics, and life history" (Mechanic, 1976, February, p. 35) (although some recent studies suggest that trust in doctors as a whole has declined) (Syrett, 2007). Another

argument in favour of implicit rationing claims that implicit rationing is superior because explicit rationing can be politically unstable.

In real world situations there are often heated debates regarding the rationing or resource allocation decisions made by governments as is the case currently with the review of neurosurgical services at Otago Hospital. There is ongoing controversy as to whether or not neurosurgery will be retained in Dunedin or centralised in Canterbury resulting in public demonstrations, Official Information Act requests from the media to the Ministry of Health, and a plethora of Oped opinions in local newspapers (Goodwin, 2010). Further pressure is put on health systems and decision makers by the ever increasing amount of medical technology and advancement that does not come cheaply. These are often explicit rationing decisions in the New Zealand context where resource allocation decisions are often made centrally rather than on a case by case basis by individual doctors. As a report by the Cancer Control Council of New Zealand has put it,

“As we better understand the genetic factors and cell biology associated with cancer we can expect more and more advances. While offering hope to cancer sufferers around the world, the huge number of compounds in development makes frightening reading for anyone contemplating the future funding required to meet these expectations” (Cancer Control Council of New Zealand, 2009, Foreword).

One area in which New Zealand is ahead of other countries is in the relatively low level of funding of pharmaceuticals compared to other OECD nations; however this does not mean that fewer medicines are funded. The “Review of Access to High-Cost, Highly-Specialised Medicines in New Zealand” to the Minister of Health Tony Ryall stated in the report that although New Zealand does have medicines at better prices than many countries, New Zealand also has less access to new high cost medicines especially in comparison to Australia (McCormack, 2010, p. 7). This is a disadvantage according to the review at the individual level to those patients who would benefit from access to some high cost medicines, even though at a population level New Zealand is at an equal level in some statistical comparisons such as life expectancy rates with other countries:

“It is important to bear in mind that differences between countries in how much they spend on medicines reflect differences in their economic circumstances, their populations, and their priorities for their societies in general and their health systems in particular...” (McCormack, 2010, p. 7).

The decision making process that is followed by PHARMAC is informed by the QALY measure or the Quality-Adjusted Life Years. So when deciding on whether or not a medicine should be approved for funding, PHARMAC will consider the cost of the medicine per the QALY as well as some notions of equity or social justice, for example, if a drug will be especially helpful for the Māori population. If the medicine is denied funding, it is because PHARMAC has decided that the

medicine does not have good value for money. The relative benefits of a medicine to its cost must be sufficiently better in comparison to other medicines that could be funded within the available budget. This shows that PHARMAC's review is not purely scientific. You could even argue that this decision making is highly subjective as they depend on the value judgements that are made by those leading the decision making process. While the values of society are important to rationing decisions, the latest medical science must be taken in to account in order to inform our values – not the other way around. As the authors of a Canadian Medical Association Journal point out in the controversy of adopting newly discovered treatments that while promising are not completely proven: “Patients should insist on evidence. They should also insist on having their views represented when decisions about where to spend research dollars are made” (Stanbrook, 2010). These decisions then are best made when considering the principle of justice that we are using, budgetary constraints, the best scientific knowledge at hand, as well as other normative considerations such as the viewpoints of the affected parties (patients and health professionals).

This is exemplified with the case of Herceptin where the media coverage heavily influenced the opinion of the public, not just in New Zealand, but similarly in Australia and the UK. Herceptin is a cancer drug marketed worldwide that is indicated for the treatment for women with breast cancer when the tumours overexpress a HER-2 protein. There have been studies on the impact that media coverage can have on the public's perception of new medical technologies, primarily new medications. In the case of Herceptin, one study showed that in the UK, “...81.4% of news reports had a positive slant towards the effectiveness of the drug and 90.6% had a negative slant towards patient access to it. Herceptin was described as a ‘wonder drug’ and ‘magic bullet’ in many of the articles” (Zealand, 2009, p. 34). This drug was at first not approved for funding by PHARMAC because it was not cost-effective, however it soon became a very political issue and the National Party even campaigned on the approval for funding of this drug in the 2008 election campaign.

I have already mentioned the example of the introduction of the Gardasil vaccine in New Zealand which followed a similar route to Herceptin on its way to funding by the government. More troubling though, to the discussion of rationing, again similarly to Herceptin, is the marketing campaign behind this vaccine. “This has involved the manufacturer and distributors funding advocacy groups, petitioning governments... encouraging governments to make the vaccine mandatory for young girls, funding educational programmes and health care professionals to give supportive presentations, and providing commercially developed economic analyses to governments in support of the vaccination programme (Rothman & Rothman, 2009; Rosenthal, 2008). The Cancer Control Council have

claimed that the pharmaceutical company pressure to adopt the product and the high level of media interest highlights the fact that balanced information must be made available to inform professional and public debate. Furthermore, the Council has claimed that the reasons for the prioritisation for this vaccine have not been made clear, given the fact that "...the basis for decisions was difficult to obtain and political involvement was again apparent" (2009, p. 48). This is a case of the government not fulfilling its duty to give balanced and scientific information that is not biased by ideology.

Regulation of medicines is a rather uncontroversial role that the government has in health as it is important that consumers can trust that the medicines that they are taking have been shown to pass a high level of tests before they are entered in to the market.

We must also not underestimate the role that NGOs can play in health. NGOs including charities and private companies can play a positive role in the promotion of health, with programs that provide incentives and communal support for maintaining healthy lifestyles such as in workplaces and local community groups. While NGOs are no doubt valuable, we must also ensure that they do not set health priorities. As we saw in the case of Gardasil and the introduction of other medications to PHARMAC's schedule of medicines, we must ensure that lobbying of certain groups does not have undue influence in the political process.

Given these examples of problems of access to new pharmaceutical products, and the controversies surrounding both decisions for and against public funding of these products in a public health system such as New Zealand, can any of the theories of justice help to rectify some of these disagreements? Can theories of justice guide the rationing process? I believe that theories of justice have the potential to improve upon the resource allocation measures.

Daniels argues that there is a need to set limits in how far we go to protect opportunity by meeting health needs, because there are many different aspects of a person's life that affect the amount of opportunity they have, and also because opportunity is not the only important social good. He says that basic liberties must be protected for example. Even if there were enough resources to meet all our health needs, it would still be fair to set limits on what health needs were met. Daniels attempts to meet the problem of the need to set limits and morally controversial rationing decisions by emphasising the need for a fair and just process to make these decisions in a just way. I have already described the process in which Daniels describes the just way to allocate health care resources. This kind of process is close in my estimation to the New Zealand process in many ways.

However, I believe that the reality of rationing health care services actually provides a strong counter argument to those theories that claim that health is a right. If health is a right in the same way as other basic rights that are universally acknowledged in free and democratic societies, then of course there must be a certain element of regulation involved. There must be those who are employed by the state who ensure that the right is not being trampled on by others, and there must be systems in place and laws there to protect it. My reading of Segall and Daniels does not give any guidance on what justice has to say about the effectiveness of enforcing bodies in the health care system. They might even agree with my summation of the practical problem of enforcement. However, their theories do suggest that a high level of regulation is perfectly acceptable. We have seen examples of this already in Segall where he has argued for a compulsory insurance scheme for risky behaviours.

In discussing the reality of rationing, I have endeavoured to show what each theory has to say in relation to this challenge, whether the challenge is from a public or private system. I have concluded that Daniels does not sufficiently overcome the challenge of rationing, and that Segall's conception of luck egalitarianism is not particularly adept at meeting this conclusion, as he dismisses to some degree the importance of receiving medical services in his emphasis on inequalities in the social determinants of health. I have argued that he still does not escape criticism as many of the social determinants of health are not within the scope of intervention that the government should be involved in. My argument for both Segall and Daniels stated that in claiming that there is a right to something, you are saying that it is something that cannot be taken away and that must be able to apply to all free and equal persons equally. But the provision of health care will always be unequal as our health needs are unequal whether they are due to a social determinant of health or whether they are a genetic predisposition or mutation. I have argued that the reality of rationing decisions that are polluted by momentary political fervour and marketing campaigns, and the fact that rationing decisions are inevitable, shows that those who argue there is a right to health must be able to show how rationing decisions can possibly be just according to the theories that they propose. I argued that Schmidtz and Anderson escape from the rationing objection relatively unscathed as they do not view health as a right in the same way that Segall and Daniels view it.

VII. Conclusion: Is There a Right to Health?

“But so much conspires against this rational ideal: ... unrestricted freedom together with our recent emphasis on individual rights as contrasted with responsibilities; a neo-liberal ideology which has stressed societal responsibility and the obligations of the beneficent state, resulting in an erosion of individual responsibility and initiative; a credit-minded culture which does it now and pays for it later ...the failure to view health holistically, that is, to understand its interdependence with educational attainment, poverty, the availability of work, housing and the density of populations, the degree of environmental pollution, and levels of stress in work, play, and love; and finally, the values and habits of the health establishment itself. One cannot hope to develop a rational health system if the parts of the whole that bear on health are moving in irrational ways” (Knowles, 1978, p. 39)

There is no denying that a healthy population is a more productive, efficient, and arguably a happier population. This essay is in no way a denial of the importance of health to individuals' welfare or goals and opportunities in life. I have argued in concurrence with Schmitdz of the importance that respect and praise for individual responsibility can have in empowering people to take care of their own health as well as the health of their families.

This paper argues that the predominant paradigm for viewing health and healthcare is too heavily focused on finding one principle of justice to justify a right to health. I have argued that by relying on a single principle of justice to guide decisions about complex health issues in an equally complex health system results in unacceptable consequences. The two consequences that I have explained are the consequences of stigmatisation and the difficulties that universal theories have with the inevitable problem of rationing. Adopting a 'universal' government-run health care system and justifying it by applying only one principle of justice is a bitter pill to swallow. This paper has presented an alternative framework for how we might view decisions about the provision or denial of health care entitlements based on a broader range of principles of justice. This has been done by assessing three theories of justice. I have argued that the theories of just health put forth by Segall and Daniels face significant challenges from the reality of rationing and the risk of creating stigmas. I have also argued that David Schmitdz's pluralistic conception of justice with its emphasis on personal responsibility is the theory that is best used when trying to determine what health entitlements we as a society could provide.

Chapter II outlines Daniels's arguments for a right to health based on the Rawlsian principle of equal opportunity: health is of special moral importance because health affects our opportunities. His case for health care entitlements was also based on procedural justice. Daniels sees resource constraints as the primary limit to his theory and argues that decision makers must make sure that health care

entitlements are based on a fair, open, and revisable process that does not have any guaranteed outcomes. The amount and kinds of entitlement will look differently on the social and economic conditions at any given time.

We then saw the argument from the luck egalitarian perspective of Segall who argued against Daniels' theory, as he did not think that equality of opportunity was broad enough in its scope to encompass groups in society that did not have life plans that affected their employment, such as the elderly. Segall argues instead that health is not of special moral importance, but that society has the responsibility to provide basic needs including health based on the principle of equality of welfare. He then applies luck egalitarian concepts to health care distribution in order to differentiate how we should treat those who are worse off due to bad luck versus bad option luck. Segall, who sees irresponsible behaviour as the primary limit to his theory, concludes that we do not have to abandon those who become injured or ill due to bad option luck if a mandatory insurance scheme were put in place as a part of a universal health care system that was designed to recoup the costs of treating those injured from risky behaviour.

I have argued that both Daniel's and Segall's cases for a right to health are based on the premise that ideally society would have the capability and moral mandate to provide universal healthcare and ensure the equal impact of the social determinants of health. As this is not possible in the real world due to the lack of sufficient resources and other priorities and values that society holds dear outside of health, they seek for a way to justify not only the broadening of entitlements, but also a justification for reducing the number of entitlements. I have concluded that Daniels theory suffers from his lack of concern with personal responsibility. The fact that he purposely leaves it out of his theory is troubling to the account of justice that I use, which argues that principle of justice that encourage the internalization of responsibility as preferable to principles that externalize responsibility. I have also argued that Daniels' lack of commitment and specificity as to what kinds of health care services are justifiable is too vague to give us clear guidance as to what a just health system might look like. I have also argued that Segall's theory is too broad and encompasses health situations that do not require any duty for society to treat. Compensation for bad luck that is not life threatening but detrimental in some way would be covered under his theory. I have argued using Elizabeth Anderson's concept and Schmditz's principle of equality that not only do the demands of compensating individuals for what they perceive to be unfair disadvantages (due to bad luck) such as being born the wrong sex, places an inordinate burden on society and is disrespectful to those who we classify as unequal because of who they are.

Using Schmitz's pluralistic theory of justice I have argued against the concepts of Daniels and Segall by claiming that a right to health cannot be justified by one principle alone. I have argued that we have a right to health in so far as that it is unjust for any agent to recklessly or intentionally harm our physical or mental health. It is a basic liberty and fundamental principle of justice that I should be free from bodily and psychological harm from others around me, including the state. This is fundamental, that no one should have power over my body or mind even with the best of intentions. If I wish to harm myself, I must have the right to do so as long as it does not harm anyone else. This is why, for example, we have laws that dictate the ethical requirements of those wishing to conduct experiments on live human subjects. It is widely considered unethical to experiment on humans without their informed consent. We must guard against the possibility of imposing our will on others even in the name of scientific and medical progress or in the name of public health. The health of future generations must not be marred by the injustices of the past as we saw in the case of the findings of the Cartwright Enquiry (Cartwright, 2009), where experiments were being done on those who did not know they were experimental subjects.

I have also argued that due to the complex nature of health needs, entitlements that we as a society may choose to provide must be based on a principle of justice that will depend on the health issue at stake. There is no one principle that we could use that would cover both maternity care and health promotion programs for obesity, for example. This is a different way of viewing the ideal state of health in a nation as well. Where Segall and Daniel in my estimation see universal healthcare as the pinnacle, the ideal in my view is for individuals to have the skills, resources, and confidence to take ownership of their own lifestyles. Failure in this regard is one of the leading causes of illness and unnecessary death in modern developed countries.

Using Schmitz I have argued, leads us to ask under what circumstances can there justifiably be government intervention. I have distilled from a range of possible principles, two principles that are more relevant in the context of health: the principles of need and desert. I have argued that equality and reciprocity are important and could be used but that need and desert should take priority to be used as principles that are used to justify government intervention. All four principles form the bases of the alternative framework that I propose should be used to guide decisions about provision or denial of health care services.

I believe that the following steps should be used to justify the creation of future health programs (including programs that are designed to influence the social determinants of health), but they can also be used to evaluate existing programs, policies, and regulation. Any government health program

has to be justified by at least one principle of justice. The principle of need should be considered first as in the context of health, need can be a matter of life or death, or mean a state of debilitating pain and anxiety. The second principle that should be considered is the principle of desert, primarily in its promissory sense so that we are ensuring that people have the opportunity to be healthy. I have already described in the case of obesity for example that a program designed to provide support for those wishing to change their lifestyles for the better is one way of providing these individuals a chance to take responsibility for their lives and is also a way to give them a chance to be healthy in the future. The principles of reciprocity and equality should be used to guide how institutions behave. In the health sector it is important the different institutions, whether public or private, national or local, be able to work together effectively for the good of the community. The principle of reciprocity is an essential part of fostering a community of justice where people feel free to do good rather than protect their own patch. The principle of equality should also be used to guide how institutions implement policies to ensure that all groups of the population have equal capacity to take advantage of health care services that are offered. For instance, if language is a barrier to some group accessing a particular service, this should be addressed so that information is disseminated in different languages and in a variety of media so that more people are informed about the existence and benefit of a service. If the principles of justice put forward in this framework are met, then the result will be programs that are:

1. Cost effective. The costs of implementing and running a program must be measured against the financial and social costs of not running it so that it is not an overly cumbersome burden to society.
2. Not at the cost of our fundamental basic rights.
3. Managed effectively. Programs should not be implemented half-heartedly, and must have sufficient funding and staffing.
4. Unintended consequences are taken in to account.
5. Independent to a certain degree from the political whims at any given time so that policies are not just based on what is popular, but are also based on sound medical and technical knowledge . For example the decision to fund a drug should not be influenced by the media or lobby groups, as was the case with the government decision to publicly fund Herceptin.

If we as a society choose, as New Zealand and many developed countries have done, to pool resources as a society to provide health care services, we must first be wary and indignant of any escalation in the intrusion of government health policy in the way we live our day to day lives. We have laws and systems in place that protect individuals from being mistreated by the health system whether they are public or private. This does not mean that no one is mistreated in public health systems. In New Zealand alone over the last few decades there have been outrageous instances of

neglect, abuse, and disrespect in our health care system. There are also worrisome instances of abuse and neglect in our aged care residences that are certified and audited by the government. These two instances and the public outrage that they rightly elicit have brought significant changes in order to ensure that abuse and neglect does not happen in the future. The fact, however, that they happened at all in a public health system tells us that public health systems must be set up with strict ethical requirements on the treatment of patients in order to protect patient rights, and the implementation of these requirements must be regulated and thoroughly monitored.

We must be realistic about the costs of running a tax payer funded universal health system, and whether the benefit to individuals is worth the price that they pay. Is it really worth it to the average middle income worker to pay a high tax rate and still not receive subsidized oral care as an adult? Or that one's rare medical treatment is not subsidised and so one's expensive treatment is viewed as not being worth the cost of treating? These are pragmatic decisions that we reasonably disagree on, but should not be shocked or appalled that this is the case when this is something that we have chosen. If we are truly appalled the system must be changed. Governments cannot provide adequate services for all or even most people, contain costs so that they are not an unjustifiable burden, and at the same time allow for individual lifestyle choices. If we say that we want a universal health care system we will have to content ourselves either with a financially unsustainable system that requires high levels of taxation, intrusive government regulation of our individual lifestyle choices, or mediocre or low quality care. Or maybe a little of all three.

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