

# Just Healthcare in an Aging Society: The Need for a Human Flourishing-Based Understanding

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## Abstract

Current theories of justice describe the arrangement of institutions for a just society, ones that seek to demonstrate equal concern and respect for all. However, the link between theories of justice that guide decision-making arrangements for intuitions and justice for individuals is not clear. This is particularly evident in relation to healthcare, where egalitarian theories of justice fail to account for the outcomes experienced by individuals. Introducing a case study that describes one man's healthcare experience in a large regional city hospital in Australia, this article argues that healthcare, particularly in an aging society, must move beyond the biomedical understanding of health, and seek more broadly to promote human flourishing. With a foundation in virtue ethics, the article then proposes an alternate understanding of justice in healthcare that addresses the highlighted limitations of egalitarian theories.

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## I. Introduction

Any discussion of the requirements of justice in healthcare must first be clear about what is meant by the term "justice." In recent times, as liberalism has emerged as the predominant political philosophy, understandings of justice have been based on principles of freedom, equality and neutrality.<sup>1</sup> Building on the assumption that society should be ordered to promote these principles, "justice" became embedded with political

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<sup>1</sup> Douglas B Rasmussen and Douglas J Den Uyl, *Norms of Liberty: A Perfectionist Basis for Non-Perfectionist Politics* (Pennsylvania: Pennsylvania State University Press, 2005), 19.

philosophical theories that sought to describe the arrangement of social institutions in such a way as to demonstrate equal concern and respect for all.

Along with political and legal institutions, healthcare is an institution that plays a pivotal role in society. This is because it is the primary societal institution charged with promoting, restoring and maintaining health in those circumstances when it is compromised. Healthcare, therefore, can be seen as a concern of justice. When considering how theories of justice might apply to this particular institution, we need to also identify the underlying purpose of theory. In this case, more than merely satisfying intellectual inquiry, the purpose of a theory of justice in healthcare is to guide decision-making to support just outcomes.

In relation to healthcare, the number and types of decisions that may be subject to assessments of justice are vast. For example, in the broadest sense, healthcare decisions concern the national or regional co-ordination of services and policy-making within individual healthcare institutions. Much of the recent literature on justice in healthcare has as its focus decisions made at this level. But the most fundamental healthcare decisions are made at the “bedside,” where healthcare practitioners and their patients decide on the most appropriate and available treatment. The differing contexts in which healthcare decisions are made also provides an opportunity for differing considerations of justice.

Justice in healthcare is ineradicably associated with demonstrating equal concern and respect for all. In this article I argue that current theories of justice that focus on the structure of societal institutions to allocate resources fail to capture the justness of outcomes that flow from treatment-based decisions. To address this limitation, I sketch an alternate theory of justice in healthcare that has a foundation in virtue ethics.

The article is structured in three parts. In the first part, I introduce a case study that describes one man’s healthcare experience in large regional city hospital in Australia.<sup>2</sup> The case study provides the context for the subsequent parts of the article. The second part outlines recent understandings of justice in health, and where applicable, healthcare. This part highlights why these theories fail to capture the essence of justice in healthcare.

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<sup>2</sup> The case study has been drawn from the personal experience of the author in her role as a registered nurse. While loosely based on a particular episode of care, all potentially identifying personal information has been changed.

It demonstrates that in an aging society where there are many people who are living with and ultimately dying from chronic disease, the provision of increasingly invasive and technologically driven healthcare does not necessarily guarantee just outcomes.

In the third part of the article, building on the approach of recent scholars of virtue ethics, I argue that healthcare, particularly in an aging society, must include more than treating narrowly defined biomedical understandings of disease. I introduce the notion that healthcare should be directed toward promoting human flourishing. I then propose an alternate understanding of justice in healthcare that addresses the limitations of egalitarian theories of justice. In conclusion I argue that if we pause to consider healthcare in relation to human flourishing, decision-making that takes into account those features of our human lives that are equally important as our biological functioning will promote just outcomes.

## **II. Case Study**

Jack was a 75 year-old man. He had been married for many years and had two adult children. Jack and his wife lived in a small town where there were limited healthcare facilities. Jack had a long history of progressively worsening heart failure. Jack's heart failure was so severe that he had minimal exercise tolerance. He was regularly admitted to hospital for treatment of acute episodes of pulmonary oedema (accumulation of fluid in the lungs) that made it very difficult for Jack to breathe. It was one such episode that prompted Jack to visit his local general practitioner. After briefly assessing Jack, the general practitioner decided that Jack was in urgent need of acute care and arranged for him to be transferred to a hospital.

Jack was taken by ambulance to a hospital nearly 100 kilometres from home. He was assessed by a doctor in the emergency department of the hospital before being transferred to the cardiac medical ward under the care of his regular cardiologist. Despite optimum treatment with medications, Jack's condition deteriorated, and the day after admission, he experienced cardiac arrest. After a short period of resuscitation, Jack's spontaneous circulation returned and he was transferred to the coronary care unit for close observation.

The cardiologist decided that the only treatment option available to help support Jack's worsening cardiac function was to insert pacing wires in each of the ventricles of the heart. Pacing wires can be inserted by accessing the left ventricle through one of the large veins that lead to the heart (trans-venous approach), or by making a small incision through the chest wall (epicardial approach). As the former approach is less invasive, and does not require a general anaesthetic,<sup>3</sup> this was the approach that initially was undertaken.

Unfortunately the cardiologist was unable to successfully place the pacing wires using the trans-venous approach and the procedure was abandoned. Jack was subsequently referred to the cardiac surgical team to assess his suitability for placement of the pacing wires via an epicardial approach. After reviewing Jack's substantial medical history, and his current (very poor) cardiac function, the anaesthetist concluded that it would be unlikely that Jack would survive the general anaesthetic required for this procedure. However, should Jack's cardiac function improve with the use of medications, then the operation could be reconsidered.

During this time the level of nursing care and general assistance that Jack required each day steadily increased. He could no longer shower himself or walk the short distance to the toilet. He spent the majority of the day "resting" on the bed and at times seemed quite agitated and distressed. He could not seem to find a position in the bed where he was comfortable and wriggled around constantly. From time to time even the hospital gown he was wearing and the bedsheets were irritants and so he would throw them off. During a consultation with the cardiologist, Jack asked if he would be able to return home to be nearer his wife. Given his precarious cardiac function, and the fact that there were no medical facilities in Jack's hometown that could provide the high level of care he required, this question was quickly dismissed. There was no discussion of Jack's concerns about his continuing hospital admission.

As a result of Jack's poor cardiac function, his other vital organs were increasingly under-perfused and beginning to fail. Without the bi-ventricular pacing wires the only viable option was to try and improve Jack's cardiac function with the use of inotropic medications. While these medications can improve overall circulatory function, they

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<sup>3</sup> Helmut Mair et al., "Surgical Epicardial Left Ventricular Lead Versus Coronary Sinus Lead Placement in Biventricular Pacing," *European Journal of Cardio-thoracic Surgery* 27, no. 2 (2005): 235-42.

are associated with an increased risk of death and other cardiovascular events.<sup>4</sup> For this reason they are often administered in a setting where there is provision for continual invasive monitoring. In the facility where Jack was a patient this occurred in the intensive care unit (ICU). Jack was subsequently referred to the intensive care specialist and transferred to the ICU.

Upon arrival in the ICU, Jack was attached to cardiac monitoring and urged to lay still while the invasive lines used to monitor his blood pressure and infuse the inotropic medication were inserted. He also underwent further diagnostic tests to assess his fluctuating cardiac function. Jack's stay in intensive care lasted only a couple of days and during this time there was significant improvement in the function of his heart and other vital organs. Mindful that the improvement would be transient, at the point when they believed that the result was optimal, Jack underwent the operation to place the ventricular pacing wire. The initial results following the admission to ICU and the operation were promising. As a result of his improved cardiac function Jack was able to walk a few metres with standby assistance, he could breathe more easily and he was able to communicate with his family and staff.

However, before he was well enough to be discharged back home to his family his condition again deteriorated. The significant improvement he had initially experienced reverted and he once again was in a position where, as a result of his minimal cardiac function, he could not get out of bed, could barely open his eyes and struggled to speak more than a couple of words at a time. He became incontinent and could not tolerate the touch of the hospital gown or any bed clothes. Recognising that all options for medical treatment were now exhausted, a decision was made to not attempt to resuscitate Jack at the point when his heart failed completely. Although Jack had been visited by his wife on the morning that this decision was made, she needed to return home and was not there the next day when he passed away.

Given the very poor cardiac function that Jack had when he presented at the hospital, the fact that he died from cardiac failure was not an unexpected outcome. Jack, like most people, sought access to healthcare in response to his deteriorating health, but

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<sup>4</sup> Alexandre Mebazaa et al., "Levosimendan vs Dobutamine for Patients with Acute Decompensated Heart Failure: The Survive Randomized Trial," *Journal of the American Medical Association* 297, no. 17 (2007): 1888.

whether the healthcare that he received could be considered just is open to question. This is not because Jack was denied access to any healthcare resource instituted with the aim of sustaining his life. Rather, it was because the decision to provide Jack with this technologically advanced, “last chance” invasive treatment meant that he experienced a prolonged, isolated and undignified death. That Jack’s death could be considered unjust implores us to closely examine how it is that we understand justice in healthcare.

Justice is a notion that transcends many areas of society and consequently, many different types of philosophical inquiry. In the liberal egalitarian tradition that dominates much current political philosophy, equal concern and respect for all is considered the hallmark of a just society.<sup>5</sup> In this sphere, ensuring that people are treated equally implicitly requires the equal distribution of a particular metric, with resources, welfare or capabilities being the most common.<sup>6</sup> Where there is a less than equal distribution, there is an expectation that steps will be taken to rectify what has been assessed as a disadvantage that is unjust.<sup>7</sup> The effect of unjust distribution can be seen in unfavourable social positions or even unsatisfied tastes, but is probably most commonly associated with inequalities in income and wealth.<sup>8</sup>

More recently, disparities in health have captured the interest of political philosophers.<sup>9</sup> Instrumentally valued because it allows us to realize our opportunities and preferences, avoidable disparities in health are seen as particularly unjust.<sup>10</sup> For example, it seems particularly unjust for one group of people to experience high levels of chronic illness due to social factors, such as where they live. Consequently, different egalitarian-based theories of justice have been developed to describe the societal obligation to minimise disparities in health.<sup>11</sup> Building on the increasing literature on the social determinants

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<sup>5</sup> See for example, Amartya Sen, “Equality of What?,” *The Tanner Lecture on Human Values* 1 (1980); Ronald M. Dworkin, *Sovereign Virtue: The Theory and Practice of Equality* (Cambridge: Harvard University Press, 2000); Elizabeth S. Anderson, “What Is the Point of Equality?,” *Ethics* 109, no. 2 (1999): 287-337.

<sup>6</sup> Norman Daniels, “Equality of What: Welfare, Resources, or Capabilities?,” *Philosophy and Phenomenological Research* 50 (1990): 273-274.

<sup>7</sup> Samuel Scheffler, “What Is Egalitarianism?” *Philosophy & Public Affairs* 31, no. 1 (2003): 13.

<sup>8</sup> *Id.*, 13.

<sup>9</sup> Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Cambridge: Polity, 2012).

<sup>10</sup> Norman Daniels, *Just Health: Meeting Health Needs Fairly* (New York: Cambridge University Press, 2008).

<sup>11</sup> Madison Powers and Ruth R. Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (New York: Oxford University Press, 2006); Daniels, *Just Health*; Shlomi Segall, *Health, Luck, and*

of health, however, these theories acknowledge that healthcare has a comparatively limited effect on remedying health disparities. Their focus, therefore, is on describing the ways in which the fundamental causes responsible for health inequality can be addressed.<sup>12</sup> Justice in healthcare, subsequently, is solely distributive, which fails to capture the effect of those interpersonal relationships that are the essence of healthcare. Three of these theories will now be outlined and then applied to Jack's case in order to highlight this significant limitation.

### **III. Egalitarian Theories of Justice in Health & Healthcare**

#### **A. Equality of Opportunity**

Recognising that healthcare is but one of many socially controllable factors that influence health outcomes, Professor of Medical Ethics Norman Daniels provides a Rawlsian account of health justice that outlines what a just society should provide in order to protect the health of its citizens.<sup>13</sup> Observing that health is crucial for the pursuit of jobs and careers, Daniels posits that Rawls' principle guaranteeing fair equality of opportunity is the appropriate principle of distributive justice for regulating institutions designed to promote health.<sup>14</sup> Rawls relied on this principle to distribute resources in such a way as to counter the opportunity advantages some individuals received by virtue of being born into a wealthy family or one of high social standing. Daniels recognised that it could also counter those disadvantages resulting from poor health by seeking to promote normal functioning, and subsequently, the normal range of opportunities to pursue their life plans.<sup>15</sup> After applying the extended Rawlsian principles to institutions, health inequalities that result from an unjust distribution of the socially controllable factors affecting health is, according to Daniels, unjust.<sup>16</sup>

While Daniels makes it clear that access to healthcare is not the only societal mechanism

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*Justice* (Princeton: Princeton University Press, 2009); Venkatapuram, *Health Justice*.

<sup>12</sup> Daniels, *Just Health*; Venkatapuram, *Health Justice*; Segall, *Health, Luck, and Justice*.

<sup>13</sup> Daniels, *Just Health*, 11.

<sup>14</sup> *Id.*, 58.

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*, 101.

for protecting and promoting health,<sup>17</sup> he also recognises that any healthcare system will at some point need to decide how best to distribute finite healthcare resources.<sup>18</sup> This is because the principles of justice that Daniels espouses, while appropriate to guide the distribution of the social determinants of health, are simply too general and too indeterminate to resolve many reasonable disputes about how to allocate resources fairly to meet health needs.<sup>19</sup> Despite the fact that arguing for the special moral importance of health and then justifying limit setting may seem paradoxical, adopting a process that provides reasoned and fair limits to care is, in the circumstance of scarce resources, according to Daniels, appropriate.<sup>20</sup> The process for setting limits developed by Daniels and his colleague James Sabin is termed “Accountability for Reasonableness.”<sup>21</sup> The appeal to procedural justice to supplement the equality of opportunity, Daniels believes, is not an abandonment of the principle. Rather, fair process is needed to resolve disputes about allocation that are not addressed by the more general principles.<sup>22</sup>

Daniels’s theory provides an account of health justice that parallels Rawlsian justice by seeking to equitably distribute resources in a way that promotes the opportunity for individuals to pursue the life plans they have chosen. However, narrowly confining health to the absence of disease means that, despite Daniels’ recognition of the importance of the social determinants for positive health outcomes, the resources he focuses on equitably distributing are those associated with healthcare. While procedural fairness is an important element of justice in healthcare, it does not adequately consider the individual outcomes that result from a just distribution. This is because it does not adequately consider clinical decision-making.

One reason why “Accountability for Reasonableness” inadequately supports just clinical decision-making is that the goal to which these decisions are directed are

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<sup>17</sup> *Id.*, 21. Daniels states that “if we think health care is the only way society has of protecting health, then ... we might (mistakenly) infer that health inequalities are unjust when access to health care is unequal.”

<sup>18</sup> *Id.*, 103.

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*, 104.

<sup>21</sup> Norman Daniels and James Sabin, *Setting Limits Fairly: Can We Learn to Share Medical Resources?* (New York: Oxford University Press, 2002). The four essential elements of “Accountability for Reasonableness” are: a publicity condition that involves transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; procedures for revising decisions in light of challenges to them; and a regulative condition that ensures the first three conditions are met.

<sup>22</sup> Daniels, *Just Health*, 110.



distinct from those policy level decisions around the allocation of resources. Clinical decisions are based on individual health needs, whereas decisions supported by the “Accountability for Reasonableness” are limit-setting decisions made at the level of the institution or health service regions. A paradigmatic example comes from the National Institute for Health and Care Excellence (NICE). This Institute produces guidance on the use of healthcare technology within the National Health Service in England and Wales using the “Accountability for Reasonableness” framework.<sup>23</sup> Recognising that their obligation is to determine which resources are most likely to improve population health, NICE recommends the use of a healthcare technology if it is assessed as improving the length and quality of people’s lives.<sup>24</sup> In this assessment, it is assumed that “a day or indeed an hour of life in full health has the same value, no matter who lives it.”<sup>25</sup>

In contrast, the determination of a clinical need is based on a constellation of reasons that are connected with a particular individual, and directed to ultimately promote their individual health. These decisions are qualitatively different from other priority setting decisions.<sup>26</sup> The basis of justification at these two different levels or types of decision-making is difficult to reconcile. This was demonstrated in a study conducted by Lydia Kapiriri et al. that evaluated the suitability of “Accountability for Reasonableness” framework for healthcare priority setting across different levels of decision-making.<sup>27</sup> In all cases, there was a reluctance of healthcare practitioners to ration care at the bedside. Although there were evidenced-based criteria, these were often “adjusted” and the reasons for the adjustments were not publicised.<sup>28</sup> The experience highlighted by Kapiriri et al. suggests that Daniels’ account of just health, even when supplemented by “Accountability for Reasonableness,” does little to support just clinical decision-making.

The moral imperative supporting Daniels’ theory of just health is the pivotal role

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<sup>23</sup> Richard Cookson, “Justice and the Nice Approach,” *Journal of Medical Ethics* 41, no. 1 (2015): 99.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*, 100.

<sup>26</sup> Kristine Bæroe, “Priority Setting in Health Care: On the Relation between Reasonable Choices on the Micro-Level and the Macro-Level,” *Theoretical Medicine and Bioethics* 29, no. 2 (2008): 93.

<sup>27</sup> Lydia Kapiriri, Ole Frithjof Norheim, and Douglas K. Martin, “Priority Setting at the Micro-, Meso- and Macro-Levels in Canada, Norway and Uganda,” *Health Policy* 82, no. 1 (2007): 78.

<sup>28</sup> *Id.*, 90.

that health plays in ensuring that people have the opportunity to pursue and realise their life plans.<sup>29</sup> When people are affected by serious disease, injury or illness, their ability to participate to the full extent in a range of opportunities is restricted. Efforts aimed at restoring health therefore will enable them to enjoy the range of opportunities that their natural skills and talents would usually permit. Constructing his theory on this imperative, Daniels relies on the narrow understanding of health as the absence of disease that he believes is objective and value-free.<sup>30</sup> Acknowledging that avoiding normative judgements of health may be controversial, he does not attempt to resolve this, preferring instead to limit his theory to understandings of health that are classified by biomedical scientists as abnormal or pathologic departures from normal functioning.<sup>31</sup> One perceived benefit of this reasoning is that if health can be objectively measured, a claim on others in relation to a health need is also an objective claim that is more easily justified.<sup>32</sup>

Applying this theory to Jack's case it is evident that, as Jack was not denied access to any form of treatment directed to treat his heart failure, there is no reason to assess this treatment as anything other than just. In fact, it could be objected that providing Jack with this level of care was an inappropriate allocation of resource and therefore an unjust distribution, not for Jack but for other people with health needs that could not be met due to a lack of available resources. Because of Jack's age and his severe cardiac disease, the normal range of opportunities to pursue this life plans were all but exhausted — Jack's opportunities were in the past. Others who might be younger and more likely to live longer could still have a reasonable opportunity to pursue life plans if provided with the appropriate resources. This assessment is one that Daniels could endorse, having previously argued that there are justifiable reasons to limit the amount of resources spent on life-saving treatment for those who are already reached the end of "normal life span."<sup>33</sup> That Daniels' theory could limit resources to people like Jack has been recognised as a potentially fatal limitation by scholars, such as

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<sup>29</sup> Daniels, *Just Health*, 30.

<sup>30</sup> *Id.*, 38.

<sup>31</sup> *Id.*, 42.

<sup>32</sup> *Id.*, 38.

<sup>33</sup> Norman Daniels, "Justice between Age Groups: Am I My Parents' Keeper?," *The Milbank Memorial Fund Quarterly. Health and Society* (1983): 512.

political philosopher Shlomi Segall.<sup>34</sup> Consequently, Segall prefers to assess justice in healthcare by the contribution that it makes to overall welfare.

## **B. Equality of Welfare**

An alternative to Daniels's general principles, supplemented with fair procedural processes, is to consider distributing healthcare resources based on the contribution that they make to individual welfare. Understandings of distributive justice that consider access to advantage<sup>35</sup> or equality of welfare<sup>36</sup> as the appropriate metric for a just society have been referred to as "luck egalitarian." They essentially incorporate the idea that the equal moral worth of all requires that persons should not end up worse off than others due to reasons that are beyond their control.<sup>37</sup> Segall offers a luck egalitarian account of justice in health and healthcare that suggests distributive justice requires correcting disadvantages for which individuals cannot be held responsible.<sup>38</sup> This is because he believes that it is unjust for individuals to be worse off than others due to outcomes that it would have been unreasonable to expect them to avoid.<sup>39</sup>

The foundational concern with welfare means that any health condition perceived as disadvantageous can make a justifiable claim for healthcare. This is reflected in Segall's assertion that a just health policy, according to the luck egalitarian view, requires society to try and rectify any health-related disadvantaging condition that the individual could not have reasonably avoided.<sup>40</sup> In contrast to Daniels who believes that the primary rationale for providing healthcare is to prevent or treat a departure from normal functioning,<sup>41</sup> Segall opines that all preventable disadvantageous conditions that are un-chosen should be eliminated.<sup>42</sup> This means that future options for human enhancement can be included. Consequently, according to the luck egalitarian view,

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<sup>34</sup> Shlomi Segall, "Is Health (Really) Special? Health Policy between Rawlsian and Luck Egalitarian Justice," *Journal of Applied Philosophy* 27, no. 4 (2010): 344-58.

<sup>35</sup> Gerald A. Cohen, "On the Currency of Egalitarian Justice," *Ethics* 99, no. 4 (1989): 907.

<sup>36</sup> Richard J. Arneson, "Equality and Equal Opportunity for Welfare," *Philosophical Studies: An International Journal for Philosophy in the Analytic Tradition* 56, no. 1 (1989): 82.

<sup>37</sup> Segall, *Health, Luck, and Justice*, 64.

<sup>38</sup> *Id.*, 94.

<sup>39</sup> *Id.*, 13.

<sup>40</sup> *Id.*, 127.

<sup>41</sup> Daniels, *Just Health*, 154.

<sup>42</sup> Segall, *Health, Luck, and Justice*, 76.

as a matter of justice there is a societal obligation to provide healthcare for any condition that is disadvantageous, able to be addressed by biomedical intervention and would be unreasonable to expect the individual to avoid.<sup>43</sup>

Segall's reference to the societal obligation suggests that decision-makers should consider allocating and funding healthcare based this luck egalitarian premise. Absent any other alternative, clinicians making treatment decisions would be expected to provide healthcare within the same constraints, with the caveat that basic healthcare needs should first be met.<sup>44</sup> The theory offered by Segall, then, requires a two-step process in its application at the clinical level. First, clinicians are required to determine whether the patient has presented with a basic healthcare need, a concept that has long been recognised as being notoriously difficult to define.<sup>45</sup> Segall suggests that this includes alleviating pain, curing illness and "compensating for other needs when they can't be cured."<sup>46</sup> The indeterminate breadth of this statement means that in essence, little guidance will be gleaned from Segall's theory to support just clinical decision-making during the first step.

The second step requires assessing the degree of responsibility that the patient should be required to assume for their condition. This is because in those circumstances where two or more equally needy patients were vying for access to a scarce or limited resource, luck egalitarianism advocates that an individual who is responsible for their disadvantage has a weaker claim than a person whose disadvantage is a consequence of brute luck.<sup>47</sup> Requiring individuals to avoid certain conditions fails to acknowledge the multifactorial complexities of many health conditions that people experience. For example, it is now well accepted that smoking contributes to cardiovascular disease, yet is not solely responsible. Genome-wide association studies have identified about 30 genetic variants that may increase the possibility of developing coronary artery disease,<sup>48</sup> but in many instances it is the interaction between a genotype and environmental

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<sup>43</sup> *Id.*, 127.

<sup>44</sup> *Id.*, 76.

<sup>45</sup> Timothy Caulfield and Amy Zarzeczny, "Defining 'Medical Necessity' in an Age of Personalised Medicine: A View from Canada," *BioEssays* 36, no. 9 (2014): 815.

<sup>46</sup> Segall, *Health, Luck, and Justice*, 76.

<sup>47</sup> *Id.*, 349.

<sup>48</sup> W Gregory Feero et al., "Genomics of Cardiovascular Disease," *New England Journal of Medicine* 365, no. 22 (2011): 2098-2109.

agents that result in the disease. So while a cursory assessment may determine that it would be reasonable to expect an individual to avoid smoking related diseases, this is overly simplistic and distorts understandings of justice that rely on this foundational assumption.

Even if it were plausible to expect people to avoid certain activities or behaviours that compromise their health, requiring clinicians to withhold needed healthcare on this basis is problematic. In fact, Segall observes that “we might think that healthcare providers ought to remain neutral between prudent and less prudent patients because to do otherwise would mean assigning to medical staff the role of policing their patients.”<sup>49</sup> Despite acknowledging that this would surely have a detrimental effect on important trust relationships, which is undesirable, Segall does not address this concern.<sup>50</sup> It is difficult to avoid the conclusion that “grossly intrusive and moralising judgements” of individual choices would be required in order to determine whether an individual’s level of health or well-being is the result of circumstances that it would have been reasonable to expect them to avoid.<sup>51</sup> So while Segall suggests that clinicians should not be required to triage their patients according to degrees of personal responsibility, clinicians are the ones in receipt of the relevant information required to make such an assessment. It is unclear therefore how this would occur if not at the bedside.

Could the luck egalitarian account of justice in healthcare describe the justness of the outcome in Jack’s case? Recall that in this account there is no obligation to provide healthcare for those who suffer bad luck as the result of their voluntary choices. While there is no information to suggest that Jack’s condition was the result of his bad-option luck, and even if there was, Segall argues that meeting health needs is a moral requirement that is external, and prior to, luck egalitarian distributive justice.<sup>52</sup> Importantly, Segall’s account would also give priority to those with the most urgent health needs, and therefore would support providing Jack with any treatment that he required to maintain his biological health. According to this account, the fact that the pacing wires were successfully implanted shows that the healthcare that

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<sup>49</sup> Segall, *Health, Luck, and Justice*, 350.

<sup>50</sup> *Id.*

<sup>51</sup> Anderson, “What Is the Point of Equality?,” 310.

<sup>52</sup> Segall, *Health, Luck, and Justice*, 13.

Jack received was consistent with this understanding of justice in healthcare. It does not, however, consider the outcome or effect of this allocation on Jack's welfare. Rather, it implicitly assumes that access to these resources is just.

### C. The Capability Approach

More recently, scholars of the capability approach have directed their attention to just health. As an interdisciplinary approach that brings together normative, empirical and policy concerns, the focus on human well-being has it well placed to address this issue.<sup>53</sup> Asserting that health has a greater intrinsic value than wealth, philosopher and sociologist Sridhar Venkatapuram suggests that a just society is one that is explicitly attentive to the influence of social arrangements on the causes, persistence, constraints, levels and distribution patterns of health and longevity.<sup>54</sup> Incorporating his understanding of health as a person's ability to achieve or exercise a cluster of basic human activities or capabilities, Venkatapuram presents a theory of social justice that explicitly recognises a moral right to the capability to be healthy.

This theory relies heavily on the work of the eminent philosopher Martha Nussbaum, who argues that there is a foundational list of political principles that should inform the way that social institutions are structured. The principles reflect the intuitive idea of a life that is worthy of the dignity of a human being. The inherent dignity held by all humans, Nussbaum argues, exerts a moral claim for the development of certain human abilities and forms the basis of her capability approach.<sup>55</sup> The human abilities she refers to as "Central Human Capabilities" are:

1. being able to live a normal lifespan;
2. having good health;
3. maintaining bodily integrity;
4. being able to use senses, imagination and think;

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<sup>53</sup> Su-ming Khoo, "Health Justice and Capabilities: A Turning Point for Global Health?," *International Sociology* 28, no. 2 (2013): 156.

<sup>54</sup> Venkatapuram, *Health Justice*, 14.

<sup>55</sup> Martha Nussbaum, *Women and Human Development: The Capabilities Approach* (New York: Cambridge University Press, 2001).

5. having emotions and emotional attachments;
6. possessing practical reason to form a conception of the good;
7. having social affiliations that are meaningful and respectful;
8. expressing concern for other species;
9. being able to play; and
10. having control over one's material and political environment.<sup>56</sup>

Venkatapuram incorporates this list of “Central Human Capabilities” to describe the content of a capability to be healthy.<sup>57</sup> Following Nussbaum’s reasoning, he suggests that all human beings exert a moral claim for a capability to be healthy in order to live a life that is worthy of the equal human dignity in the modern world.<sup>58</sup> Venkatapuram therefore argues for an entitlement to a sufficient threshold of each individual central human capability that constitutes a health capability.

Providing a conceptual vehicle for evaluating the descriptive aspects of the determinants, consequences, persistence, and distribution of health, these components can be seen as constituting the “what” or metric of health justice. However, Venkatapuram does not go further to suggest “how” or even “if” an equal distribution of this metric of health justice could or should be achieved.<sup>59</sup> By strongly advocating for socially informed epidemiological research to address health inequities, Venkatapuram does not consider how Jack’s healthcare might be assessed against the requirements of justice. Rather, in his account, epidemiologists would examine the social and political factors that contributed to Jack’s cardiac failure and require that steps be taken to address these. In doing so, the overall aim is to reduce inequities in health between populations, but this provides no guidance in relation to Jack’s circumstances.

What is of particular interest in reviewing these different theories is that although they purport to focus on justice and health, how any of the theories intersects with the provision of healthcare is, significantly, given little weight. Those that do focus

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<sup>56</sup> *Id.*, 78-80.

<sup>57</sup> Venkatapuram, *Health Justice*, 141. Venkatapuram posits that the cluster of ten basic, inter-dependent and iterative capabilities and functionings reflect the biology and physiology of the human organism as well as including other capabilities and functionings which reflect the neediness, sociability and capacity for reasoning of the human animal.

<sup>58</sup> *Id.*, 143.

<sup>59</sup> *Id.*, 144.

predominantly on the distribution of scarce resources. They do not consider the allocation of those healthcare resources that might not be necessarily scarce enough to warrant this consideration. Further, although the theories might generate principles designed to demonstrate equal concern and respect for all, they do not explicitly acknowledge that treatment-based decisions are also a concern of justice. Highlighting that egalitarian principles that seek universality cannot account for the outcomes that result from the application of the principles, these theories implicitly assume that equitable or sufficient access to those resources directed toward treating illness or disease is the primary, if not sole, requirement of justice. Whether this assumption is correct will now be examined.

#### **IV. The Moral Status of Healthcare & Human Flourishing**

The theories of justice proposed by Daniels, Segall and Venkatapuram consider distribution as the primary focus of justice in health and, to the extent that they address it at all, healthcare. This is consistent with the notion that society's obligation to assure adequate access to healthcare for all must be thought of as a justice-based obligation in order to capture the moral stringency associated with many claims for access to healthcare.<sup>60</sup> The strength of this moral claim, therefore, is inextricably linked with the instrumental value ascribed to having or being in a state of good health.<sup>61</sup> While these claims support the appropriate distribution of healthcare resources, they also inherently assume that access to healthcare will improve health. However, if, as research on the social determinants of health has consistently demonstrated,<sup>62</sup> healthcare has a comparatively limited effect on overall health, its moral importance must have an alternate foundation.

People most commonly seek access to healthcare in response to deteriorating or

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<sup>60</sup> Leonard M. Fleck, "Just Health Care (II): Is Equality Too Much?," *Theoretical Medicine* 10, no. 4 (1989): 302.

<sup>61</sup> Daniel M. Weinstock, "How Should Political Philosophers Think of Health?," *Journal of Medicine and Philosophy* 36, no. 4 (2011): 429.

<sup>62</sup> Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *The Lancet* 372, no. 9650 (2008): 1661-9.



poor health experienced as pain, suffering, or a general change in their usual functional ability. In many instances fluctuations in health are a temporary, yet often recurring feature of the human condition. As such, they can also be understood as representations of our innate vulnerability.<sup>63</sup> When we think about our need for healthcare because of, for example, a minor infection, our vulnerability is not a state that we can attribute to the “other.” Unlike categories such as race, sex or status that might be used to situate those differently from ourselves, vulnerability is a persistent corporeal attribute, a state that we will all experience (albeit to different degrees) at some point in our lives.<sup>64</sup> We are all vulnerable to the effects of injury, disease, illness and disability, any, or all of which can leave us in varying degrees dependent on the support and care of others.

In addition to these states, which may or may not be temporary, there is another aspect of our existence as biological creatures that exposes us to periods when we are vulnerable. Describing her political conception of the person, Nussbaum observes that “we are temporal animal beings who begin as babies and end, often, in other forms of dependency.”<sup>65</sup> That is, across the lifespan, even if we avoid most forms of disease or disability, we will at some point experience vulnerability associated with our chronological age. The realisation that vulnerability is an enduring dimension of the human condition implores the provision of care and support through societal institutions and structures that mediate, compensate and lessen its unwanted effects.<sup>66</sup>

A just society that acknowledges our inherent vulnerability generates the means and mechanisms whereby individuals have the resources and resilience they need to confront its social and practical implications.<sup>67</sup> It is in this role that healthcare finds its special moral importance. As Professor of Law Daniel Weinstock has suggested, healthcare matters not “because of what it *does* but because of what it *means*.”<sup>68</sup>

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<sup>63</sup> Henk ten Have, “Respect for Human Vulnerability: The Emergence of a New Principle in Bioethics,” *Journal of Bioethical Inquiry* 12, no. 3 (2015): 401.

<sup>64</sup> Onora O’Neill, *Towards Justice and Virtue: A Constructive Account of Practical Reasoning* (Cambridge: Cambridge University Press, 1996), 192.

<sup>65</sup> Martha Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (Cambridge: Harvard University Press, 2007), 160.

<sup>66</sup> Martha Albertson Fineman, “The Vulnerable Subject and the Responsive State,” *Emory Law Journal* 60 (2010): 10.

<sup>67</sup> *Id.*

<sup>68</sup> Weinstock, “How Should Political Philosophers Think of Health?,” 429.

That by providing treatment for health concerns, healthcare is important not only because it aims to cure disease and reduce pain and suffering, but also because it demonstrates the extent to which people in society, particularly those who are most vulnerable, are treated as deserving of “equal care and respect.” Here we note a subtle linguistic shift from the need for equal “concern” and respect to equal “care” and respect, suggesting that health “care” involves some positive action in relation to health.<sup>69</sup>

If healthcare is the institution charged with providing the care and respect essential for a just society, then it must at some point determine what might be included as a legitimate “health” concern. A detailed discussion of this question is beyond the scope of this article, but in general terms, the synergistic relationship between science and the medical profession has over the years encouraged acceptance and integration of biomedical understandings of health as the absence of disease.<sup>70</sup> Accordingly, healthcare has primarily been directed toward reversing, or in those cases where that is not possible, treating the symptoms caused by the pathology or physiological processes responsible for reduced health.<sup>71</sup> One consequence of adherence to a strictly biomedically-focused understanding of health is that in the provision of healthcare, significant aspects of the human condition are frequently undervalued and therefore overlooked. While achieving optimal states of biological functioning is an undeniably important goal, it is not the only goal to which human lives are directed.

If healthcare is important because it demonstrates care and respect for individuals, particularly those who are vulnerable, then we need to consider more inclusively what this requires. It is apparent that there is no simple, straightforward answer to this infinitely broad question, and several different possibilities for approaching it. One such possibility comes from the position of virtue ethics, in which actions are guided by practical reasoning, and doing the right thing is explicated by being virtuous.<sup>72</sup> While acting in a virtuous manner will ultimately lead to a good life, philosopher and virtue ethics

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<sup>69</sup> Virginia Held, *The Ethics of Care: Personal, Political, and Global* (New York: Oxford University Press 2006), 30.

<sup>70</sup> Donald Irvine, “The Performance of Doctors: I. Professionalism and Self Regulation in a Changing World,” *British Medical Journal* 314, no. 7093 (1997): 1540-2.

<sup>71</sup> Mark Schweda and Georg Marckmann, “How Do We Want to Grow Old? Anti-Ageing-Medicine and the Scope of Public Healthcare in Liberal Democracies,” *Bioethics* 27, no. 7 (2013): 358.

<sup>72</sup> Julia Annas, “Virtue and Duty: Negotiating between Different Ethical Traditions,” *The Journal of Value Inquiry* 49, no. 4 (2015): 609.

advocate Julia Annas points out that although one can flourish by cultivating virtues, “neither flourishing nor the virtues are aimed at *my* well-being *as opposed to* those of others.”<sup>73</sup> As healthcare is inextricably connected with the good of others, particularly those who are most vulnerable, rather than solely focusing on biological functioning, healthcare should be directed more broadly toward human flourishing.

Historically associated with the work of Aristotle,<sup>74</sup> human flourishing is a complex notion that engenders an elaborate conception of the good.<sup>75</sup> In *Nicomachean Ethics* Aristotle referred to the highest of all attainable human goods as *eudaimonia*,<sup>76</sup> the end (*telos*) of human life. Traditionally this ancient Greek term was translated as “happiness.” However, this term implies a subjective assessment of a particular state, and as a goal of human activity, *eudaimonia* also encompasses objective elements.<sup>77</sup> Subsequently, although not a literal translation, the term “human flourishing” has emerged as the preferable translation of *eudaimonia*, as it more readily encompasses both objective and subjective elements.

There are differing views about how human flourishing is best understood. Based on the assumption that the *telos* or natural function of human beings is to flourish, political philosophers Douglas Rasmussen and Douglas Den Uyl offer a neo-Aristotelian interpretation of the character of human flourishing.<sup>78</sup> For these scholars, the development of a modern political framework first requires an understanding of the “good” and how it might be achieved.<sup>79</sup> In developing their theory, Rasmussen and Den Uyl insist that morals and politics should be strictly separated but argue that efforts to provide human beings with the dispositions and rational ability to live good and virtuous lives requires political support.<sup>80</sup> Conceiving the ultimate “good” or *telos* of human life

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<sup>73</sup> *Id.*

<sup>74</sup> Martha Nussbaum, “Nature, Function, and Capability: Aristotle on Political Distribution,” *Oxford Studies in Ancient Philosophy Supplementary* 1 (1988): 145-54.

<sup>75</sup> Douglas B Rasmussen, “Human Flourishing and the Appeal to Human Nature,” *Social Philosophy and Policy* 16, no. 1 (1999): 2.

<sup>76</sup> Aristotle, *The Nicomachean Ethics*, trans. David Ross (New York: Oxford University Press, 2009), x.

<sup>77</sup> Rasmussen, “Human Flourishing and the Appeal to Human Nature,” 9.

<sup>78</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 117-20. Offering this understanding, the authors acknowledge that the claim that human nature is teleological is controversial. Therefore, they believe that restricting theology to the biological domain, rather than any “external” cosmos or designer, addresses this concern.

<sup>79</sup> *Id.*, 14.

<sup>80</sup> *Id.*

as flourishing, they maintain that this good is an objective way of living constituted by basic goods such as:

1. sociability;
2. knowledge;
3. leisure;
4. aesthetic appreciation;
5. creativity;
6. moral virtue;
7. health;
8. pleasure;
9. self-esteem; and
10. practical wisdom.<sup>81</sup>

Conceptualising these generic characteristics as a package of capacities whose realisation is required for human flourishing, a human life that fails to exhibit each of these “generic” goods in some form is incomplete, according to Rasmussen and Den Uyl.<sup>82</sup> They also point out that these goods and virtues are more than the mere means to achieving human flourishing; they are expressions or realisations of it, and therefore intrinsically valuable in their own right.<sup>83</sup> By incorporating each of these characteristics, human flourishing arises as a continuous process of living well.<sup>84</sup>

In a similar neo-Aristotelian vein, Nussbaum argues that a package of central human capabilities is required in order to reflect a life that is truly human. Although in her more recent writing the “Central Human Capabilities” have been based on the “intuitive idea of human dignity,”<sup>85</sup> these evolved from an earlier understanding of Aristotelian basic spheres of experience.<sup>86</sup> Believing that an objective understanding of the human good was compatible with an ethical theory based on individual characteristics or

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<sup>81</sup> *Id.*, 79.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.*, 13.

<sup>85</sup> Nussbaum, *Frontiers of Justice*, 70.

<sup>86</sup> Martha Nussbaum, “Non-Relative Virtues: An Aristotelian Approach,” *Midwest Studies in Philosophy* 13, no. 1 (1988): 32-53.

virtues, Nussbaum describes a package of essential needs required for human functioning that are grounded in non-relative human experience.<sup>87</sup> Those up front are related to our inevitable mortality and our vulnerable human bodies. The human ability and need for physical sensation, cognitive capability, practical reason and the need for affiliation and humour round out this iteration of her understanding of the human good.

Over time the spheres of human experience have been modified, as too has their primary purpose. Abandoning Aristotle's notion of human nature in preference for a more egalitarian and pluralistic understanding of the human good, Nussbaum shifts the focus of her work from purely ethical questions to more political concerns regarding the just distribution of capabilities necessary to provide human beings with the capacity to choose to live as they think best.<sup>88</sup> Consequently, it has evolved into a partial theory of social justice rather than an account of the human good or flourishing.<sup>89</sup> However, it does retain a particular focus on individuals,<sup>90</sup> and given the foundation upon which the list was developed, the current central human capabilities (as included previously) can still inform an objective understanding of human flourishing.

Nussbaum's list varies slightly from the list of generic goods proposed by Rasmussen and Den Uyl, but the essential capacities (or capabilities) that feature in both lists, and therefore can be considered to constitute human flourishing, are:

1. life and health;
2. the need for sociability and affiliation with others;
3. an ability to think and imagine creatively;
4. knowledge and practical reason; and
5. pleasure through leisure or play

Collectively these capacities describe the ultimate end of a "good" human life in a way that respects the widely held views about human reality, but take "experience

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<sup>87</sup> Martha Nussbaum and Amartya Sen, *The Quality of Life* (New York: Oxford University, 1992), 251.

<sup>88</sup> Catherine H. Zuckert, "Aristotelian Virtue Ethics and Modern Liberal Democracy," *The Review of Metaphysics* 68, no. 1 (2014): 64.

<sup>89</sup> Nussbaum, *Frontiers of Justice*, 75.

<sup>90</sup> *Id.*, 166.

as its source and guide.”<sup>91</sup> Consequently what is “good” for a human being does not exist abstractly; rather it is embodied in the actualisation of what Rasmussen and Den Uyl refer to as “individuating potentialities.”<sup>92</sup>

For clarity, the generic goods in the list will be referred to as “generic capacities” in the remainder of the article. The generic capacities that constitute human flourishing only become real and determinate when they are given form by the decisions that people make. The contribution that such decisions make to human flourishing is more than merely satisfying a preference, and Rasmussen and Den Uyl argue that they can be assessed objectively.<sup>93</sup> Nussbaum too believes that human flourishing, assessed in light of particular experience, is fully compatible with Aristotelian objectivity, stating that, “the fact that a good and virtuous decision is context-sensitive does not imply that it is right only relative to, or inside a limited context, any more than the fact that a good navigational judgment is sensitive to particular weather conditions shows that it is correct only in a local or relational sense.”<sup>94</sup>

Although human flourishing is something that is objective and highly personal, it cannot be attained in isolation. As Aristotle makes clear, *philia* (friendship) is one of the constituents of human flourishing.<sup>95</sup> Rasmussen and Den Uyl describe *philia* in terms of human sociality and note that this particular aspect of human flourishing is not something that is abstract, but expressed within specific interpersonal relationships.<sup>96</sup>

I now return to the notion that healthcare is important because it is the primary societal institution that explicitly demonstrates care and respect. What it is that the institution is caring about, however, is more than just biological functioning. The scope of healthcare is the individual whose *telos* is toward *eudaimonia* or human flourishing. While biological functioning vital for good health is an essential characteristic of human flourishing, it should not be isolated from other equally important characteristics, each of which constitute partial realisations of a person’s

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<sup>91</sup> Peter M Cicchino, “Building on Foundational Myths: Feminism and the Recovery of Human Nature—A Response to Martha Fineman,” *American University Journal of Gender Social Policy & Law* 8 (2000): 78.

<sup>92</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 123.

<sup>93</sup> *Id.*, 81

<sup>94</sup> Nussbaum and Sen, *The Quality of Life*, 258.

<sup>95</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 141.

<sup>96</sup> *Id.*, 161.

flourishing.<sup>97</sup> Although it may not be possible or practical for generic capacities such as pleasure, leisure or play to be promoted during a healthcare interaction, it can still be considered in the process of treatment decision-making. Similarly, the importance of interpersonal relationships should not be neglected, as these are central, particularly when a patient is confronted with an acute illness and experiences episodes of heightened vulnerability.<sup>98</sup>

Accepting that good health is valuable not as a mere means to human flourishing but as an expression of it imagines human flourishing as a continuous process of living well over the whole life course, not merely selected snippets of it.<sup>99</sup> A focus on the whole life course enables us to see more clearly our essentially social nature and the ways in which vulnerability and dependency are experienced by all human beings at different times.<sup>100</sup> It is of particular relevance as the end-of-life is approaching and opportunities to enact those decisions that promote flourishing become limited. Consequently, although all of the generic capacities are required for flourishing, the value or weight given to each will at times vary. It is this characteristic that makes human flourishing unique to a particular individual. In the provision of healthcare it therefore requires that individual potentialities are respected.

If healthcare is directed toward promoting health as an essential of capacity of human flourishing, how then might justice in healthcare be understood? I have previously highlighted the limitations associated with relying solely on understandings of justice that focus on distribution. Assessing justice in healthcare as something more than an appropriate distribution of resources suggests that there are at least “two different senses” in which the term “justice” is used in this context.<sup>101</sup> Rasmussen and Den Uyl postulate that in the first sense, justice deals with the structural conditions that allow for relationships constitutive of human flourishing to take place.<sup>102</sup> This is the principal sense upon which the preceding theories of justice are founded. The second

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<sup>97</sup> *Id.*, 79.

<sup>98</sup> Alisa L. Carse, “Vulnerability, Agency, and Human Flourishing,” in *Health and Human Flourishing: Religion, Medicine, and Moral Anthropology*, ed. Roberto Dell'oro and Carol Taylor (Washington D.C.: Georgetown University Press, 2006), 35.

<sup>99</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 131.

<sup>100</sup> John Cottingham, “The Question of Ageing,” *Philosophical Papers* 41, no. 3 (2012): 382.

<sup>101</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 160.

<sup>102</sup> *Id.*, 162.

sense relates to the integral role that achieving and maintaining social relationships are to human flourishing.<sup>103</sup> If sustaining these relationships is vital, then understanding and fostering the enabling conditions for these relationships is imperative.<sup>104</sup> According to Rasmussen and Den Uyl, justice in this second sense, therefore, is concerned with regulating conduct or behaviour to promote human flourishing. Justice then is the normative principle of “rendering each his proportionate due.”<sup>105</sup> Although Rasmussen and Den Uyl’s description of justice in this sense is seen as one of the virtues essential for an individual’s human flourishing, it affirms more broadly that justice is essentially about what is “due” to others.<sup>106</sup> Thinking about the role of healthcare as an institution that demonstrates care and respect, then justice in healthcare can be understood as rendering to each what they are due. That is, to more broadly promote human flourishing.

Although the generic capacities provide a framework for a flourishing life, they do not provide that life with specific content or direction. The realisation of a flourishing life will depend on each person’s particular attributes, beliefs, circumstances and interests.<sup>107</sup> Collectively, these elements will influence the weight or value attached to each of the generic capacities, and be reflected in the practical decisions that are made.<sup>108</sup> However, these decisions are not made in a vacuum. As inherently social beings, the decisions that people make will be influenced by the interpersonal relationships they form and maintain across a variety of different circumstances. In any healthcare interaction, this will include healthcare professionals such as doctors, nurses and allied health professionals, as well as those people with a significant relationship with the patient. With this in mind, justice in healthcare therefore evinces decision-making that takes account of all the generic capacities required for human flourishing.

### **A. Just Healthcare Decisions in an Aging Society**

Justice in healthcare therefore requires a philosophical shift, from the social contract

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<sup>103</sup> *Id.*, 161.

<sup>104</sup> Nikola Biller-Andorno, “IAB Presidential Address: Bioethics in a Globalized World — Creating Space for Flourishing Human Relationships,” *Bioethics* 25, no. 8 (2011): 436.

<sup>105</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 162.

<sup>106</sup> Thomas Nys, “Justice and Solidarity: Compound, Confound, Confuse,” *Diametros*, no. 43 (2015): 73.

<sup>107</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 150.

<sup>108</sup> *Id.*



tradition that informed egalitarian theories of just health to one that understands a just society as one accepting of the inevitability of vulnerability and providing the circumstances under which people can flourish.<sup>109</sup> In doing so, it also seeks to address the limitations of egalitarian theories that provide general universalizable principles. While giving priority to the particular, the normative approach described as “justice for flourishing” also aims to link theory and practice. To demonstrate how, the next part of the article revisits Jack’s admission to hospital and treatment for end-stage heart failure.

At the time of Jack’s admission to hospital, his health was so severely compromised that his life itself was precarious. In these circumstances it is reasonable to assume that Jack’s life and health were the generic capacities that were weighted or prioritised above all others. Acknowledging that, should Jack’s life end, so would any prospect of continued flourishing, his complementary generic capacities were relegated to the background. Promoting biological health was the priority, and this was realised through a series of treatment decisions. As Jack’s heart failure progressed the decisions regarding treatment, particularly potentially life-saving ones, became increasingly complex and multifactorial. Not only did the process involve consideration of possible treatment options, but these were being made in the context of a dynamic emotional environment characterised by much uncertainty.<sup>110</sup>

The uncertainty for Jack concerned not only his cardiac function, but also how long he would stay in the hospital away from his home and his wife. Consequently, resulting in part from the high level of physical and emotional dependency, the decisions that Jack was required to make may not have been made with the same clarity and directive purpose as they would normally.<sup>111</sup> Although Rasmussen and Den Uyl assert that proper weighting of the generic capacities for flourishing is “only achieved by individuals using practical wisdom at the time of action to discover the proper balance *for themselves*,”<sup>112</sup> it is apparent

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<sup>109</sup> Eva Feder Kittay, “Can Contractualism Justify State-Supported Long-Term Care Politics? Or, I’d Rather Be Some Mother’s Child,” in *Ethical Choices in Long-Term Care: What Does Justice Require?*, ed. World Health Organization (Geneva: World Health Organization, 2002), 95.

<sup>110</sup> David W. Frost et al., “Patient and Healthcare Professional Factors Influencing End-of-Life Decision-Making During Critical Illness: A Systematic Review,” *Critical Care Medicine* 39, no. 5 (2011): 1183.

<sup>111</sup> Ronald M. Epstein and Richard L. Street, “Shared Mind: Communication, Decision Making, and Autonomy in Serious Illness,” *Annals of Family Medicine* 9, no. 5 (2011): 454.

<sup>112</sup> Rasmussen and Den Uyl, *Norms of Liberty*, 147.

that this may not always be possible. Situations such as Jack's illustrate just how our innate vulnerability can be associated with substantial dependency, and thereby generate an almost unyielding tension. In the setting of biomedically driven healthcare, informed by ever-increasing biotechnological advances, how and/or when should treatment decisions be based solely on sustaining our biological functioning at the cost of all other generic capacities essential for human flourishing?

The pioneering bioethicist and philosopher Daniel Callahan noted more than 30 years ago that the "compelling power of technology ... is not simply that a technology may kill a germ or restore a breath ... the real power of technology lies in its seeming capacity to turn what seems fixed and unavoidable into the malleable and contingent."<sup>113</sup> Technology therefore makes it possible to do something, which for most healthcare practitioners is preferable to the alternative, which is to do nothing.<sup>114</sup> While failing to integrate new biomedical knowledge, or the technologies it generates, for the benefit of those in need is perceived as undermining the societal obligation to care for those who are vulnerable,<sup>115</sup> framing treatment decisions as a binary choice (to do something technological or nothing at all) neglects those options that are not technological or biomedically focused, yet still contribute to human flourishing. It also disregards the cost or compromises associated with the decision to institute these options. To analyse whether this is also unjust, the circumstances of Jack's admission can be considered in light of the alternate theory of justice: "justice for flourishing."

In the virtue ethics-based "justice for flourishing" account that I have sketched, rather than seeking universality, the focus is on the particular. Specifically, it looks to see whether healthcare treatment decisions contribute to an individual's human flourishing. Much of the decision-making in relation to Jack's care was influenced by the doctors caring for him, and narrowly focused on maximising his cardiac function. The decision to persist with optimising Jack's cardiac function so that he could undergo the procedure to insert biventricular pacing wires essentially sought to fulfil the purpose of improving or 'saving' his life. While extending a period of living with end-stage

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<sup>113</sup> Daniel Callahan, "Transforming Mortality: Technology and the Allocation of Resources," *Southern California Law Review* 65, no. 1 (1991): 205.

<sup>114</sup> *Id.*

<sup>115</sup> Leonard M. Fleck, "Just Health Care (I): Is Beneficence Enough?," *Theoretical Medicine* 10, no. 2 (1989): 169.

heart failure is impossible to evaluate as good or bad in a normative sense, some note that such life extension may not always “serve the patient’s best interest.”<sup>116</sup> Sharon Kaufman and colleagues report that the technological imperative — the value accorded to technological solutions — has been criticised by observers of medicine for four decades for being a means without an end, an activity carried out in the absence of reflective consideration for its implications, especially regarding quality of life and end-of-life care.<sup>117</sup>

Viewing Jack as a mere receptacle for his heart, rather than as a whole person constituted by his past and present, social and environmental circumstances meant that the “solution” was directed to address only one (albeit important) aspect of his overall needs. Maintaining this narrow focus entirely neglected that there might be alternatives to continued, and at times invasive, monitoring and escalating treatment. It also did not consider the “costs” associated with providing such care. Those costs were not necessarily financial but included the loss of privacy and dignity that Jack experienced while he was in the hospital, as well as the time that he was away from his wife and home. The cost of failing to acknowledge that Jack was dying from, rather than living with end-stage heart failure,<sup>118</sup> meant that rather than saving his life, Jack’s admission to hospital resulted in a prolonged and at times isolated process of dying.

Jack died in the hospital; a death that was undignified, restless as opposed to peaceful, and absent of those relationships that were essential for his ultimate flourishing. It could not have been assessed as a “good death,” but more than this, it was an outcome that for Jack was also unjust. Not because he did not have access to healthcare or advanced technologies designed to improve cardiac function, and not because he died. The unjustness was because the care that was provided failed to demonstrate concern and respect for all but one of the generic capacities that constituted Jack’s human flourishing.

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<sup>116</sup> Sharon R Kaufman et al., “Ironic Technology: Old Age and the Implantable Cardioverter Defibrillator in US Health Care,” *Social Science & Medicine* 72, no. 1 (2011): 11.

<sup>117</sup> *Id.*, 10.

<sup>118</sup> Liz Lloyd, “Mortality and Morality: Ageing and the Ethics of Care,” *Ageing and Society* 24, no. 2 (2004): 237.

## **V. Conclusion**

In this article I have argued that justice in healthcare is ineradicably associated with demonstrating equal concern and respect for all, but that theories of justice that focus only on the structure of societal institutions fail to capture the justness of outcomes that flow from treatment-based decisions. By applying three egalitarian based theories of justice to the admission of a man with end-stage heart failure I have demonstrated that they fail to guide decision-making or assessments of justice in particular healthcare circumstances.

To address this limitation, I have sketched an alternate theory of justice in healthcare that has its foundation in virtue ethics. By acknowledging the inevitability of our vulnerability, the normative approach described as “justice for flourishing” advocates not just for healthcare resources, but promotion of the broad range of circumstances under which people can flourish. With a focus on individual beliefs, attributes and circumstances, the biomedical focus of healthcare that relies upon sustaining biological functioning is seen as just one of the generic capacities required for human flourishing. Justice in healthcare, therefore, rather than mandating an equitable allocation of the preferable metric such as resources, welfare or capabilities, ultimately requires due consideration of the bundle of capacities that constitute human flourishing.

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