Chapter II: KANTIAN ETHICS AND THE FUNCTIONS OF HEALTH CARE

Kant's Ethical Theory

Kant offered three different formulations of the categorical imperative which he considered to be the only moral norm that all human beings must observe.[31] All three express the same idea, albeit with different emphasis. The following presentation is adapted from Sullivan:[32]

Formula 1: Formula of Autonomy: "I ought never to act in such a way that I could not also will that my maxim should be a universal law."

Formula 2: Formula of Respect for the Dignity of Persons: "Act so that you treat humanity, whether in your own person or in that of any other, always as an end and never as a means only."

Formula 3: Formula of Legislation for a Moral Community: "All maxims that proceed from our own making of law ought to harmonize with a possible kingdom of ends as a kingdom of nature."

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31 Kant (1788)

32 Sullivan (1994)

For the purpose of my discussion it is not important if the three formulations are exactly compatible or what the limits of their application are. Instead I want to highlight the key ideas behind them and apply them to the question of just health care.

The first formulation expresses the idea that we should not act in ways that are intended for reasons that when expressed as a principle, cannot be universalized. Killing, violence, coercion, and deception are examples for actions which cannot be universalized in that way.[33] This formulation is particularly important for justifying the negative rights that every human being should enjoy, such as freedom from harm and interference.

But the first formulation does not only secure the negative rights of people. It also is a compelling foundation of the basic entitlements people have in any society and a rejection of libertarianism, which denies such entitlements. The argument is that a principle of nonbenevolence cannot become a maxim that can be willed as a universal law. This is so because it is part of the human condition that we are vulnerable to diseases, accidents, impoverishments, and many other threats to our agency as rational beings. We, in principle, can at any time become dependent on the help of

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33 O'Neill (1989)

others in order to pursue any rational goal at all, and would will the help of others in such circumstances. Since we cannot consistently will a principle of nonbenevolence and, at the same time, understand this aspect of the human condition, a principle of nonbenevolence cannot become a universal law. It would involve us in a contradiction between the willing of a principle and the willing which is natural under circumstances when the principle is suposed to be applied. From this follows that its opposite principle, benevolence, must be regarded as a universal law. Since diseases and accidents are typical threats to rational agency for humans, any account of what follows from a law of benevolence should justify at least the public provision of some forms of health care.

However, for the purpose of applying Kantian ethics to justice in health care the second formulation is equally or even more instructive. According to Kant, respect for the dignity of persons is considered to be an important justification for the positive rights people enjoy. This comes from their being rational agents, rather than from any other contingent feature of themselves, a particular society, or tradition. Positive rights include, among others, property rights, freedom of expression, political participation, welfare rights, and rights to mutual aid.[34] As I will argue

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34 O'Neill (1989); Herman (1993); Rosen (1994)

below, the second formulation also gives a direct justification for securing access to some forms of health care through public provision.

The third formulation concerns Kant's notion of an ideal community in which there would only be free and equal citizens.[35] This is the most comprehensive way to express Kant's ethics and has found wide application in the work of John Rawls. To simplify, one may say that Rawls' work, as well as that by many other liberal political philosophers, represents a comprehensive and explicit interpretation of what it would mean to live in a community of free and equal citizens, or as Kant would put it, in a Kingdom of Ends.

For my purposes this third formulation is somewhat less important since I will not be concerned with an ideal community or a complete set of just institutions. Formulation 1 and 2 both include the key idea on which I will build when formulating the central functions of health care.

What do these formulations tell us about just health care? In what follows I will argue that they imply:

a) We have an obligation to be concerned with at least some aspects of our health and the health of others,

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35 Sullivan (1994)

b) We should not make central aspects of the health of others a means to fulfilling specific individual or communal purposes,

c) There are limits to our obligations to be concerned with our health and the health of others, and

d) The different functions of health care are supported by different kinds of obligations and principles.

Why Should We Be Concerned with Our Health and the Health of Others?

As explained above, the most obvious Kantian justification for being concerned with the health of others is that a principle of complete nonbenevolence cannot be universalized for human beings who are rational and vulnerable from internal and external causes.[36] The first formulation above is the basis for such a justification. I believe, however, that the second formulation is a richer and more direct source for an obligation to be concerned with the health of others and of ourselves because of the direct importance of health care for respecting others as rational agents.

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36 O'Neill (1989)

To respect others as ends in themselves implies a concern with sustaining their capacity for the kind of reasoning and action which is constitutive of their status as ends in themselves. We do not owe the same respect to animals or lifeless objects because they are not capable of the same kind of rational agency. What is distinctive about rational agency in humans is that it not only includes the satisfaction of the basic needs of survival or short term goal-directed action, but also allows for the autonomous choice of broader goals and life-plans. These broader goals are often motivated by moral ideals about how we should live, and for most people are an important source of finding meaning in life. For humans, therefore, rational agency always has the dimension of moral agency. I regard this moral agency as the most distinctive and important characteristic of human rational agency. In what follows, I will speak of human beings as moral agents rather than rational agents, putting emphasis on this part of rational agency as the foundation of our dignity. All this, in turn, has broad implications for the distribution of health care resources.

The key idea behind our obligation to make sacrifices for the health care of others is this: It is inconsistent to say that I respect a person as a moral agent and have no concern for the kind of mental and physical functioning of that person which is needed to sustain their moral agency.

And to have such a concern implies to be prepared to make a sacrifice to sustain this functioning, since otherwise the concern is not sincere.

Here we confront a critical difference between basic mental and physical functioning and a person's happiness. I can, without inconsistency, say that I respect a person as a moral agent without having much of a direct concern for their happiness, depending on the many reasons why that other person might be unhappy. But to respect other human beings as moral agents directly implies that we should also be concerned with the conditions they need to be and to remain moral agents. This is so because I cannot plausibly say that I respect you as a moral agent only as long as you happen to remain one. In particular, my concern with your basic capabilities for moral agency may well have an impact on whether or not you can continue to act as such an agent.

In our world this, in fact, is often the case. Small sacrifices by ourselves often can sustain the moral agency of others. I believe that any substantively plausible interpretation of the second formulation of the categorical imperative requires us to make such sacrifices. The same holds for our own basic health, since as part of our self-respect as moral agents we cannot plausibly be indifferent about what sustains our own moral agency.

The respect for others as moral agents, however, also implies that we should have an interest in their having available a minimum of those other means which they need to act as moral agents. Any pursuit of life plans is only possible with a minimum of means such as income, education, and other opportunities, means that Rawls has called "*primary goods*". This is important since it implies, I will argue below, that we are under a moral obligation not to exceed a certain budget for health care.

Health Care and the Ends of the Individual and the Community

Respect for the dignity of moral agents further implies that we should not reduce others to merely being the means for fulfilling our, or the community's, ends. A comprehensive interpretation of what it means not to do that, and the implications of such a principle for limiting paternalistic actions and actions intended to avoid great evil cannot be attempted here. However, it is clearly impermissible, for example, to harm others for the sake of personal happiness or to advance the specific ideals of the community. Any such harm would have to be justified by something of higher moral importance, since in this sense the "right is prior to the good", as Rawls has stated it.[37]

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37 Rawls (1971)

For health care, this argument implies that the state, for example, cannot unrestrictedly use the health care system to maximize human happiness or welfare as it would appear to be morally mandated by utilitarianism. A potential organ donor, for example, may not be sacrificed for the health of several potential recipients, even if this would maximize utility. Not sacrificing the basic liberties of individuals for community ends also rules out forms of eugenics, even if such practices were part of the shared values of a particular society. These are important arguments since they provide an unconditional protection for individuals against being sacrificed wrongfully through the health care system, protections, which neither utilitarianism nor communitarianism can provide.[38]

What I want to argue here, however, is that the non-instrumentalization of others, as part of mutually respecting our status as moral agents, also has implications for our positive obligations in health care. It implies not only that we should not cause harm for others in order to advance personal or community projects in health care, but also that we should not sacrifice the morally important positive entitlements of individuals for such projects. It is inconsistent to argue that we should never impose even a slight harm on an individual no matter how much happiness it could

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38 Lyons (1994); Holmes (1989)

bring to the community, if at the same time we generally allow individuals to die because we do not provide them with the resources needed for health care, in order to spend them instead to further our own happiness.

The restriction on harming others for our own ends can easily be supposed to be stronger than the obligation to help others in need, but this can be wrong. Harming others intentionally cannot be universalized and is therefore not permissible. Helping others in severe need is on the first formulation only covered through a duty of mutual aid, because we cannot consistently will principles of complete non-benevolence. The principle of not willfully harming others is a <u>perfect</u> obligation, meaning that it applies to all individuals whom I meet. This is not the case for the principle of benevolence, since I am not under an obligation to help every single person I meet. This is so because I cannot do this as a human being with limited means. The obligation of benevolence is, thus, an <u>imperfect</u> obligation, since it does not always apply.

It is fallacious, however, to think that a principle that does not always apply is weaker than one that does always apply in cases in which both principles apply. In such instances, the obligation to help can be stronger than the obligation not to harm, depending on the consequences the

failure to meet each of these obliagtions would have.

On this account of Kant's ethics, negligence with great consequences to another individual can be a morally greater wrong than causing more modest direct harm. I will argue below that this interpretation of Kant's ethics is a compelling account, on reflection, of how we conceive of our obligations to others with regard to the fulfillment of the basic needs of people and the basic liberties.

I cannot attempt here any discussion whether this interpretation of Kant's ethics is one he would have endorsed himself, and I, therefore, also do not assume this to be the case. My aim is rather to show that the consequences of such an interpretation are intuitively appealing and important for justice in health care and would result from Kant's account of moral reasoning. For health care this interpretation of Kant's ethics is practically very important because it implies that there may be some medical needs of others that we cannot ignore for the sake of projects of the community or ourselves. This includes projects that are neither hedonistic nor self-interested, although these obviously come to mind. It also includes projects of an explicitly moral status, such as those that advance religious or secular perfectionist ideals.

The Limits to Our Obligations

Respecting oneself and others equally as moral agents implies that we cannot be under an obligation to sacrifice our own moral agency for the sake of saving that of others even above the level of functioning that would put our survival at risk. The primary reason to prolong or improve the life of others is to allow them to remain moral agents, not survival per se. This means that we cannot be under an obligation to reduce ourselves to the level of mere survival, having sacrificed the means needed to function as moral agents. There is, therefore, clearly a limit to what we as individuals owe to others in order to meet the medical needs that unmet would doom the potential beneficiary.

On the other hand, as discussions of our obligations for mutual aid have shown, the sacrifices we can owe to others can be quite substantial.[39] An individual can indeed come upon a situation where moral obligations rightfully demand great sacrifices.

The limits of the sacrifices that we are under an obligation to make is best expressed through Amartya Sen's concept of "basic capabilities".[40] The basic capabilities

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39 Herman (1993)

40 Sen (1992)

are a mixture of our internal functional characteristics as individuals and the external means we command to function. For meeting some of the morally most important medical needs of others we may appear to be obliged to make sacrifices to the point where our own basic capabilities as moral agents are threatened. This would clearly imply bad moral luck for the individuals who have to make such sacrifices but would not reduce them to anything less than full moral agents.

I will argue below that we are under an obligation to live by a set of principles that distributes such sacrifices in a fair way. This implies that we are under a moral obligation to create institutions that on the one hand meet those medical needs that are morally central, and on the other hand avoid requiring individuals to make overly substantial sacrifices.

If this effort is successful, it would imply the important conclusion that we have moral obligations towards both those who stand to receive the benefits of the central functions of health care as well as towards those who are capable of making the sacrifices required to provide these benefits. This would constrain the institutional design of this part of health care because it would limit, based on justice, the extent to which we could pursue utilitarian or perfectionist points of view. It will turn out that our

obligation to provide others with the health care they need to function as moral agents has unexpected and wide-ranging implications for socio-economic justice in society.

Different Kinds of Health Care are Covered by Different Obligations

The last conclusion I want to draw from my interpretation of Kant's ethics is that we do not have the same kind of obligation to support morally peripheral medical needs that we have for morally central needs. I regard as central that which underlies our functioning as moral agents, and define peripheral health care needs as those that concern the quality of functioning that is clearly above the level of functioning which allows us to act as moral agents. The distinction is socially constructed, as it needs to be to take into account important differences in the functional requirements for moral agency in different cultures and socio-economic contexts. This is a point to which I will return when I define moral agency in more detail below.

An example of a peripheral need is the desire for cosmetic surgery in order to look younger in a society that places some value on looking young. If one looks older, some life-plans may not be available in such a society. But the remaining available range of plans may well be broad enough

to not justify any entitlement to surgical intervention. That is, we may generally understand ourselves as respecting others as moral agents without being prepared to make sacrifices to provide others with cosmetic surgery against the signs of aging.

From a moral point of view, the peripheral functions of health care clearly have a lower priority than the central functions of health care. This is so even if, as is frequently the case, some individual's desire for some of the peripheral functions of health care is stronger than their desire for the central functions. We do not owe others health care because they desire it but because they need it to remain functioning moral agents. This rules out a direct obligation to provide them with those services that constitute peripheral functions.

How should we provide those peripheral functions? Their fair distribution should be taken care of by insuring everyone a fair share of resources or of Rawlsian primary goods. But since even a fair distribution of resources or of primary goods would not address all of the important morally arbitrary comparative differences in life prospects between people, those who face premature death or disability have further entitlements. These, from a Kantian point of view, have their foundation in what it means to respect people with

whom we interact as moral agents.

Moral Agency and Capabilities

I now come back to the claim I made above, that there are two distinct functions of health care which we should separate for moral reasons. I argued that we cannot, when we interact with others, consistently hold that we respect them as moral agents without at least having some concern about their survival, or their risk of becoming severely disabled, either mentally or physically, and that this should guide the definition of the central functions of health care. What does it exactly mean to be a moral agent and how can this definition be used to define the central functions of health care?

What it practically means to respect others as moral agents cannot be deduced from any definition of the term moral agency or from linguistic analysis. Even if it were possible to use such means of analysis to establish the correctness of the Kantian categorical imperative (another matter beyond the scope of this effort), such an analysis would not decide about how that imperative should be applied in a specific case. Such applications always are a matter of interpretation rather than deduction and rely in part on

information about the context of their application.[41]

In that spirit I want to make a proposal about how we should conceptualize the notion of respecting others as moral agents in the context of the circumstances of: 1) very large differences in health and life-expectancy, 2) a distribution of income that would be fair if no differences in health existed, and 3) limited resources so that we cannot afford to eliminate all of the differences among individuals in health status and life-expectancy.

The first step in this interpretation is that respecting others as moral agents means respecting others for their capacity to make autonomous moral <u>choices</u>, and not because they might advance some specific ideals of the good. Beings that are not capable of making such choices we are not supposed to treat as ends in themselves, such as animals. To treat animals respectfully involves e.g. that we do not inflict pain or discomfort on them without appropriate reasons. But it does not involve that we respect the choices that they make about their lives. Thus the kind of choices that it is particularly important for us to allow other human beings to make for themselves, are moral choices. Such choices are distinctively human. We cannot even conceive of human beings without at the same time conceiving of them as

41 O'Neill (1989)

individuals who can make choices with a moral component.

Moral agency is not an empirical concept, since it involves a perspective that can only be approached by an interpretation of what actions mean to the subject involved. It presupposes intentionality, meaning that someone (at least potentially) perceives a choice as a free choice, and furthermore as a choice with normative implications. For this reason it is not possible to give a purely biological or psychological interpretation of moral agency. Moral agency cannot be equated with a certain mode of brain functioning or physical functioning in the absence of an interpretation of what that brain functioning or physical functioning signifies. We, therefore, need to refer to commonly used criteria to determine if someone is a moral agent in everyday life rather than trying to derive the meaning of moral agency from biology or psychology.

What I conceive of as a typical moral agent is a human being who self-consciously pursues an ideal of the good life. Although moral agency involves many choices with limited scope and impact, such as helping someone in need or simply going to a movie, these limited choices are best interpreted as constitutive of a larger narrative which I propose, following Rawls, to call "*the ideal of the good*" of an

individual. The paradigm case of moral agency is the pursuit of such ideals of the good over a normal life-time. What counts as an ideal of the good or as a normal life-time is again a matter of interpretation that is only possible in a specific context. But, I contend, it is part of our notion of human beings per se to conceive of them as beings that pursue life-plans, which are constitutive of their moral agency and rationality.

However, the notion of the value of having individuals choose and pursue ideals of the good should not be regarded as such an ideal itself. Moreover, the construction of justice in health care I am attempting here should not be seen as contingent on the acceptance of any such specific ideal. To use O'Neill's terminology, to conceive of others as moral agents is not an idealization of human beings but just an abstraction. The liberalism that follows from such a construction is not dependent on a specific ideal of how to live (such as the ideal of "*autonomy*"), nor on a political compromise between such ideals. It rather puts constraints of reason on the use to which alternative moral ideals of the good can be employed in the political realm. The specific constraint in question here is that ideals of the good cannot be used to justify institutions that allow certain avoidable threats to the moral agency of some to persist, since the justification of such institutions would be inconsistent with

the mutual respect of moral agents.

One must be careful not to confuse the typical characteristics of a moral agent and moral agency itself. For example, a minimum life-expectancy may be necessary to be regarded as a typical moral agent, but to live that long is not automatically to be a moral agent. Thus, despite a normal life-span, moral agency may not be possible in the face of severe mental retardation. Also, if someone can conceive of ideals of the good but, through severe poverty, does not have the means to live them, she also cannot be regarded as a fully-functioning moral agent. Thus, moral agency involves internal and external requirements, requirements about the person and her circumstances.

I believe a promising way to conceptualize moral agency is provided by Sen's notion of "*capability*", although the concept seems to be quite complex.[42] The space of capabilities is defined through the so-called "*functionings*" that an individual actually can achieve. Such possible functionings include those that actually are achieved, as well as those which could be achieved given the personal characteristics, situation, and means of the individual. The functionings themselves may be further grouped into the two broad categories of well-being and agency. Thus, there can be four

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42 Sen (1985),(1992); Nussbaum & Sen (1992)

forms of functionings: well-being and agency functionings as achieved and well-being and agency functionings as freedoms to achieve. The ability to function as a moral agent may then be thought of as involving a particularly important subset of functionings. This subset of functionings constitutes the freedom to choose and pursue ideals of the good and includes well-being functionings as well as agency functionings. Important well-being functionings may include freedom from pain or discomfort, mental health, and being well-nourished. Agency functionings may include the physical, emotional, and cognitive ability to choose and to pursue such ideals how to live like doing meaningful work, making friends, establishing a family, and participating in culture and politics.

The focus on functionings rather than income or resources allows us to see the different effects the same income, resources, or Rawlsian "*primary goods*" can have on different human beings, including those with different genetic endowments or disadvantages incurred earlier in life. For example, a person who is mentally retarded does not have the same level of capabilities that a person without such a handicap has, even if both enjoy the same level of resources or income. Differences in capability can be the result of many reasons, not all related to health. Thus, a person with better education may have a higher level of capabilities than a person with the same resources but little education.

The value of many functionings clearly depends on the ideal of the good that a person has chosen or may choose. Only the lack of the most general functionings should count as morally significant disadvantages for the purpose of conceptualizing moral agency. These are the kind of functionings one needs to have in order to choose among a variety of ideals of the good and to pursue them, rather than the functionings which are specific to some particular ideals of the good.

To illustrate that point, consider someone with a high level of achieved functionings and freedom functionings, which in this case depend for their value on the ideal of the good the person has chosen. Such a person, for purposes of justice, may be more disadvantaged than someone who has achieved less and is free to achieve less from the perspective of the ideal of the good life he has chosen, if the second individual could, in contrast to the first, also have substantive achievements in case she adopted other ideals of how to live. To give a specific example, for purposes of justice, what do we owe in the way of health care support to a happy and successful wheelchair-bound mathematician compared to an unhappy limping, uneducated, and unsuccessful factory worker? Suppose they enjoy comparable total sets of achieved functionings (although achieved functionings do not seem to be easily comparable), since the

mathematician enjoys highly valuable and sophisticated special functionings, whereas the factory worker has a wider range of more basic functionings available.

I argued above that for justice in health care we should be concerned with maintaining or restoring each individual's capacity to formulate and implement a broad range of life plans. This would imply that the mathematician in the wheelchair should have greater health care entitlements than the limping factory worker, since the former suffers a more significant restriction on his moral agency. In Sen's terms, we should regard him to be more entitled to health care since he has lost more basic capabilities.

If this analysis of the space of capabilities does not misinterpret this difficult concept, it seems to me possible to conceptualize moral agency in the following way:

To have, as a matter of fact, that level of capability, that allows one to choose and pursue ideals of the good.

Capability levels are determined by a mixture of internal and external characteristics of a person. Part of the external characteristics is the level of resources and income a person enjoys and whether the basic liberties are

available. If a just distribution of these external characteristics has been achieved in society, no one would fail to be a moral agent as long as they are not internally handicapped. Such internal handicaps concern the functional characteristics of a person, such as his mental and physical health and his life-expectancy. A person's health or life-expectancy can be such that the ideals of the good that are commonly pursued in society are not open, even with an otherwise fair share of resources or income. Some-one's disadvantages may be so great that no amount of additional resources or income would permit them to make such choices.

In a society with a fair distribution of resources and income, those with such internal limitations on their capabilities may be the only group which does not achieve full moral agency. This is the case in a society in which the distribution of resources, income, or primary goods allows those members of the least advantaged socio-economic group who are not internally handicapped at least that level of resources which is adequate to pursue some of the ideals of the good that are typically pursued in such a society. For example, in a society in which having a family with children and being able to choose among a variety of employments are typical ideals of the good, the question is whether or not the members of the lowest socio-economic group de facto have such a choice. If this is the case, their moral agency appears not

to be impaired, since they have the necessary capability level. If, in contrast, they have to accept any form of employment and risk starvation if unemployed, then full moral agency would not yet be achieved for this group.

In the United States, Germany, and other democratic industrialized countries, most external limitations on moral agency have been overcome even for the socio-economically worst-off groups. This is certainly the case for the other West European countries, since they have put in place large welfare systems. In these countries, as well as in Canada, Japan, New Zealand, and Australia, only those with internal limitations on their most basic capabilities do not enjoy full moral agency. In the next chapter, I will argue that the central forms of health care, to use Daniels' phrase, are a "*special social good*", which are in moral importance comparable to the basic liberties and basic welfare. These special goods we owe to others as part of respecting them as moral agents, rather than as a matter of distributive justice. I will then turn to the implications of this status of central health care for its total budget.