The Benchmarks of Fairness and Solidarity

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Abstract

Two concepts are often used in the arrangement of morally acceptable health care systems: Justice and Solidarity. In this paper I will discuss Daniels' benchmarks of fairness, which can be seen as a method to apply a Rawlsian conception of justice to health care systems. The benchmarks of fairness have been greatly influential in designing health care systems around the world. However, there are three problems with applying a Rawlsian conception of justice to health care. Firstly, a justice-only approach to health care could create a hostile attitude between different groups in society. Secondly, a justice-only approach tends to create humiliating procedures to determine people's rightful share of societies' resources. And thirdly, in applying a Rawlsian conception of justice to health care systems Daniels excludes the severely disabled from the scope of distributive justice. I argue that these three problems can be fixed by adding Ter Meulen's conception of solidarity as a justification for the benchmarks of fairness.

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Introduction

In political philosophy concerned with the arrangement of morally acceptable health care systems in society two concepts are often used: justice and solidarity. These concepts have been vastly influential in shaping health care systems across the world. A health care system consists of all organizations, people and actions whose primary interest is to promote, restore or maintain health(WHO).

In this paper, I will be concerned with the role of the government in creating an ethical health care system. In the last century, European health care systems have been mainly influenced by considerations of solidarity(Ter Meulen 2015). On the other hand, in the United States the health care system has been mostly based on a libertarian conception of justice(Callahan 2011). The result is a vastly different health care system. To achieve the most ethically sound health care system it is of great importance to consider the principles used in the arrangement of health care systems and if the conceptions of justice and solidarity from which these principles stem are ethically sound.

The work of Norman Daniels, an advocate of using justice to approach health care systems, became increasingly influential across the world in the past few decades. Daniels' benchmarks of fairness for health care reforms have been used to systematically review health care reforms in the United States(Daniels and Light 1996) and have helped to set up health care systems in multiple developing countries(Daniels, Bryant et al. 2000). These benchmarks of fairness are based on a Rawlsian conception of justice. In the Rawlsian conception of justice citizens are free and of equal worth. However, there is a tension between freedom and equality. A more equal distribution of goods in society often means more intervention by the government in the distribution of goods. The increased government intervention results in less freedom for the individual. Rawls balances between equality and freedom with the help of two principles. Firstly, "each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others." And secondly, "social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all"(Rawls 1973: 60). When Rawls writes 'to everyone's advantage', he means to the maximum benefit for the least well-off.

However, there is a fundamental problem with Daniels' benchmarks of fairness. Some health care philosophers have argued that the approach to health care using a Rawlsian conception of justice neglects the importance of solidarity central to health care system's design(Ter Meulen 2015). Especially in Europe, solidarity has been a very important value in shaping health care systems(Callahan 2011). Advocates of solidarity in health care often argue that using the concept of justice alone is not sufficient in reflecting on health care systems. According to Ter Meulen a Rawlsian conception of justice fails to properly value the relatedness of human beings. To value the relatedness of human beings is central in Ter Meulen's conception of solidarity(Ter Meulen 2015). In this paper I will research whether Ter Meulen's conception of solidarity can supplement the benchmarks of fairness created by Daniels in an ethically relevant way. The central question in this paper will be: Should Daniels' benchmarks of fairness be supplemented with solidarity as a justification for the benchmarks?

My strategy for answering this question consists of three parts. In the first part of this paper, I will show how Daniels' theory of just health is connected to a Rawlsian conception of justice and how the benchmarks of fairness are connected to Daniels' theory of just health care. In doing so, I also discuss some key features of Rawls' theory of justice and Daniels' theory of just health. Lastly, I explain what the benchmarks of fairness are by giving some examples and mentioning the goal of the benchmarks.

In the second part, I will discuss three problems with the application of a Rawlsian conception of justice to health care. These problems are all examples of an overarching problem: The Rawlsian conception of justice fails to completely enclose all relevant ethical considerations when evaluating health care systems. The first problem is that an exclusively justice-based approach in designing the basic structure of solidarity can lead to hostile attitude towards parties that have a claim on justice. The second problem is that an exclusively justice-based approach tends to rely on humiliating procedures in determining a person's fair share of societies' resources. The third and most significant problem is that Daniels' extension of Rawls' conception of justice to health care leads to the problem that it cannot justify arranging health care through public means for the severely disabled. Arranging health care for the severely disabled would then fall outside the scope of justice. Daniels' acknowledges this problem but cannot provide a satisfying solution for it. However,

in Daniels' benchmarks of fairness there is no exception made for the severely disabled to be excluded outside health care arrangements regulated by justice. This means that there is a gap in justification between Daniels' theory of just health care and the benchmarks of fairness, which needs to be filled in order to properly justify the benchmarks of fairness.

In the third part of this paper I will discuss how supplementing the benchmarks of fairness with solidarity as a justification for the benchmarks can solve these problems. Therefore, I propose to add solidarity as a justification for the benchmarks of fairness. According to Ter Meulen the role of solidarity is to supplement and correct arrangements in society based on principles of justice. Solidarity should not replace justice, instead solidarity should supplement justice. Ter meulen argues that where health care systems are concerned we should appeal to humanitarian solidarity. Humanitarian solidarity means that we have a responsibility to care for those who cannot take care for themselves because of shared values of humanity (Ter Meulen 2015). I will argue how humanitarian solidarity can solve the three problems I discuss in the second part of the paper. Lastly, I will discuss three objections against my proposal to include solidarity as a justification for the benchmarks of fairness.

From Rawls' conception of justice to the benchmarks of fairness

The purpose of this chapter is to show how Rawls' theory of justice as fairness, Daniels' theory of just health and the benchmarks of fairness relate to each other. I will start by explaining some important features of Rawls' theory of justice. Subsequently, I will outline how Daniels' theory of just health is an extension to Rawls' theory by showing the connection between health care and Rawls' index of primary social goods. Lastly, I give some examples of the benchmarks of fairness to show that they are the practical elaboration of the Rawlsian conception of justice applied to health care.

Three important features of Rawls' theory of justice as fairness

Firstly, Rawls' theory is a form of contract theory. This means that justice is created through a social contract which is in everybody's best interest. In order to do so Rawls introduces the original position. The original position is a hypothetical and impartial point of view. For Rawls' the fundamental principles of a just society are decided in a social contract which is created in the original position. The decisions made in the original position are made behind a veil of ignorance. This veil of ignorance means that the parties in the original position do not know their personal, social and historical circumstances in society. However, parties in the original position do know general facts about human psychology, biology, economics and other sciences. They also know which fundamental interests human beings have. Then the parties in the original position decide upon which conception of justice best serves everybody's interests(Rawls 1973).

Secondly, Rawls' theory is a liberal theory. This means that Rawls is concerned with providing a thin theory of the good. A thin theory of the good will make only minimal assumptions about what persons need to achieve their own conceptions of the good. According to liberal theory a state should interfere as minimally as possible in the pursuit of people's own conceptions of the good. More interference than absolutely necessary is seen as paternalistic(Rawls 1973).

Thirdly, Rawls conceptualizes persons as free and equal moral individuals who are both reasonable and rational. Also, persons possess two moral powers: the ability to recognize

what is just and the ability to recognize what is good. The capacity to act, understand and apply justice is called the reasonable. This is what makes persons able to find just principles in the original position. The rational is the capacity to formulate a plan of life according to one's own conception of the good and the ability pursue or revise this plan. According to Rawls the concept of justice is prior to that of the good. A just society provides the opportunity for people to follow their own conceptions of the good. This is done by distributing the primary goods fairly. Primary goods are those goods that citizens need to be able to pursue a wide range of conceptions of the good. Examples of primary goods are freedom of movement, freedom to choose among a wide range of occupations, income and wealth and fair equality of opportunity(Rawls 1973).

Daniels' extension of Rawls' conception of justice to health care

According to Rawls a just society is governed by two principles: Firstly, "each person is to have an equal right to the most extensive basic liberty compatible with a similar liberty for others." And secondly, "social and economic inequalities are to be arranged so that they are both (a) reasonably expected to be to everyone's advantage, and (b) attached to positions and offices open to all(Rawls 1973)." According to Rawls these principles are best protected by a fair distribution of the primary goods. Primary goods are those goods every rational individual should want to be able to pursue reasonable life-plans. Rawls distinguishes between primary social goods and primary natural goods. The primary social goods are those goods free and equal persons need to function as free and equal citizens. According to Rawls, it is the task of the government to distribute the primary social goods fairly. The primary natural goods are basic bodily and mental abilities such as strength or intelligence. According to Rawls a just government should not be concerned with the fair distribution of the primary natural goods. Originally, Rawls viewed good health as one of the primary natural goods and therefore outside the scope of fair distribution by the government(Rawls 1973).

Daniels, however, does not view health as one of the primary natural goods. According to Daniels health care is of special moral importance because it contributes to opportunity, which is a primary social good in Rawls' index. Being in good health is essential in order to claim a fair share from the normal opportunity range. The normal opportunity range is the

range of life plans people are reasonably able to choose from to pursue with their talents and skills (Daniels and Light 1996).

Nevertheless, this does not mean that all health care practices should be fairly distributed by principles of justice. For example, Daniels does not want to include plastic surgery for the purpose of beauty to be included in the fair distribution of health care. In order to discriminate between which health care needs should be met and which should not, Daniels introduces the notion of normal species functioning. Only health care needs that are an impairment of normal species functioning are the concern of just health care(Daniels 2007). To see why, it is important to understand how Daniels defines health and how this is connected to normal species functioning. Daniels borrows his definition of health from Boorse, who is a biomedical philosopher. Boors defines health as “the absence of disease”(Boorse 2011). Disease is a deviation from the natural functional organization of a typical member of a species. By defining health this way Daniels can circumvent the above example of plastic surgery, because a lack of beauty is not an impairment of normal species functioning and therefore not a disease. According to Daniels, normal species functioning is necessary for persons to claim their fair share of the normal opportunity range in society(Daniels 2007).

So far in this chapter I have explained what place health has in Rawls’ and by extension Daniels’ theory. Rawls originally thought that health is a primary natural good and therefore not the concern of fair distribution by the government. Daniels, however, argues that health should be of concern to a fair distribution because it contributes significantly to the primary social good ‘opportunity’. According to Daniels the focus of health care should be to bring people to normal species functioning. A focus on normal species functioning enables us to discriminate between which health care needs should be distributed according to principles of justice and which should not(Daniels 2007).

The benchmarks of fairness

The benchmarks of fairness for health care reforms have first been published by Daniels in 1996. Since then the benchmarks have changed considerably to fit the purpose of creating just health care systems for developing countries. The benchmarks of fairness are based on Daniels’ theory of just health(Daniels et al. 2005). They can be seen as the practical elaboration of Daniels’ theory. The benchmarks of fairness offer tools to evaluate policy

measures in a step-by-step way, resulting in a qualitative and quantitative analysis of how well the measure scores in terms of justice. The benchmarks of fairness are a set of principles formulated in such a way that policy-makers can 'measure' their health care system arrangements in terms of justice. To give some examples:

Benchmark 3. **Nonfinancial barriers to access**

I. Reduction in geographical maldistribution
- Facilities and services
- Personnel (mix and training)
- Supplies
- Drugs
- Clinic hours (appropriate to village routines, work schedules)
- Transportation for medical purposes

II. Gender
- Status in family regarding decision-making
- Mobility
- Access to resources
- Reproductive autonomy
- Gender sensitive provision of services, involvement of community political groups to address gender barriers

III. Cultural
- Language
- Attitude and practices relevant to disease and health
- Uninformed reliance on untrained traditional practitioners (some healers, midwives, dentists, pharmacists)
- Perception of public sector quality

IV. Discrimination by race, religion, class, sexual orientation, disease, including stigmatization of groups receiving public care

Benchmark 5. **Equitable financing**

I. Is financing by ability to pay?
- If tax based-scheme
  - How progressive (by population subgroup)?
  - How much reliance on cash payments (by subgroup)?
- If premium-based
  - Is it community-rated (by subgroup)?
  - Reliance on cash payments (by subgroup)?
- Out-of-pocket payments contribute to both
  - Main source of shifting burdens to the sick

In total there are 9 benchmarks and they roughly fall in four categories: Equality, efficiency transparency and autonomy. The first five benchmarks are mostly concerned with equal access to health care. Benchmark 6 and 7 are concerned with efficiency of health care. Efficiency is morally relevant because with the resources wasted on inefficiency people's health care needs could have been met. Benchmark 8 is concerned with democratic accountability and empowerment and benchmark 9 with patient and provider autonomy(Daniels et al. 2005).

The benchmarks of fairness have proven themselves to be highly usable for policy-makers in deciding how to design health care systems(Daniels et al. 2005). This is of great value since it is often the case that health care measures are not properly evaluated in terms of justice because it is such a complex task to decide what just health care is and how it can be achieved through policy measures. I think an important reason for this is that it is not always clear how philosophical theory about just health care should be applied in practice. The benchmarks of fairness are a great tool to apply philosophical theory on how to ethically distribute health care in a health care system.

Nonetheless, the benchmarks of fairness are not perfect. I believe that Daniels' benchmarks of fairness could be improved by adding Ter Meulen's conception of solidarity as a justification for the benchmarks. Justice, as conceived by Rawls and Daniels, misses a number of relevant ethical issues in arranging health care systems, which I will discuss in the next chapter.

Three problems of the Rawlsian conception of justice applied to health care

In the previous chapter I have shown that Daniels theory of just health and the benchmarks of fairness resulting from it are based on a Rawlsian conception of justice. In this chapter I will argue that the Rawlsian conception of justice misses relevant ethical considerations in creating morally acceptable health care arrangements in three ways. Firstly, a justice approach can lead to loss of morality by changing people's behavior into a more hostile attitude. Secondly, a justice approach runs the risk of creating humiliating institutional procedures. And thirdly and most importantly, Daniels' theory of justice leads to exclusion of the severely disabled from the scope of distributive justice. Even though Daniels is aware of this problem he cannot find a satisfying solution for it by extending his own theory.

How justice can create a hostile attitude

The first problem is that justice has the risk of replacing other values, which not necessarily leads to a moral improvement. For example, Sandel argues that benevolence precedes justice and is a more fundamental value. According to Sandel, a justice-only approach has the risk of becoming so dominant and restrictive that it destroys the relations of benevolence which were preexisting to the relations of justice. As a result, relations become colder and more hostile, which is not an improvement. Sandel illustrates his point with the example of a family. In this family relations are mostly governed by spontaneous affection and only in a small degree by justice. It almost never occurs that somebody makes an appeal to individual rights to claim a fair share. There is a spirit of generosity in distributing the goods in the family. However, a situation occurs in which the individual interests of the family members do not align. The relations between the family members change in the sense that they become increasingly dissatisfied with each other. As a result, the spirit of generosity which previously governed the relations makes way for demands of fairness and rights(Sandel and Anne 1998: 32-35). I agree with Sandel when he says that something is lost when justice takes over from benevolence. It feels as if there is a moral decline in this situation even though there is no injustice done. The moral decline is located in the hostile attitude that sometimes arises when people have competing claims of justice.

This can also be seen at a societal level. For example, in Dutch society a considerate amount of people express a hostile attitude towards guest workers turned immigrants. This is

evidenced by the PVV having 20 seats in the Dutch parliament. The PVV is committed to strict regulation for all immigrants and even stricter regulation for Islamic immigrants (PVV). Especially the regulations focused on Islamic immigrants go quite far in restricting the freedom of immigrants. Also, according to the CBS approximately between 20% and 50% percent of people in the Netherlands feel that economic immigrants should not be allowed to live and work in the Netherlands(Kloosterman 2018). There are many reasons why people feel hostility towards this group, but one of the more prominent ones is that people feel like the immigrants 'took their jobs.' These immigrants have full Dutch citizen-ship and therefore have an equal claim to justice on the Dutch government as every other Dutch citizen. Still, the hostility remains because many people feel like the immigrants are not one of them, even though they have Dutch citizenship. Because some Dutch people feel that the immigrants are not one of them, they feel robbed of opportunity whenever an immigrant gets a job when a non-immigrant is sitting home unemployed. I think that the hostility of the people expressing such an attitude towards immigrants can be explained by the fact that justice requires them to share with the immigrants even though they do not feel benevolence or a relatedness towards the immigrants.

Institutional humiliation

The second problem is that justice often tends to humiliate people at an institutional level. Many institutions in welfare states that are governed with justice have humiliating procedures for persons to obtain their rightful share. The humiliation of persons is a very serious issue since humiliation is closely tied with self-respect. Self-respect is one of the most important 'goods' a society should provide since it is at the basis of persons having a sense of value. Without a sense of value persons cannot see the realization of their life plans as a worthy pursuit and will not have to confidence to pursue them(Margalit 1998). Rawls acknowledges this as well by saying that self-respect is one of the most important primary goods to distribute equally(Rawls 1973). However, even though Rawls calls self-respect one of the most important primary goods he cannot prevent humiliation being done in the processes which carry out justice. As Margalit points out, when Rawls is talking about self-respect he is concerned with the pattern of distribution and not with the procedure of distribution. The procedure of the distribution of goods to individuals can still express vindictiveness and a lack of compassion even though it is a just distribution(Margalit 1998).

There are many examples in modern Western states of humiliating procedures. In many western countries there are conditional welfare systems in place. The conditions in these welfare systems are mainly in place to distinguish between people who are in need of welfare because of unfortunate circumstances and people who brought it upon themselves by making bad choices. The problem with this conditional approach is that the government needs a lot of information from individuals and that the welfare payments are entirely conditional on this information. In practice, this process of gathering information is often perceived as very shameful and humiliating for the individual in need of welfare(Wolff 1998). Also, it is not uncommon that the individual is treated with great rudeness. The process of gathering information and judging whether and individuals' failure is his own fault is very detrimental for the self-respect of an individual. Especially for those who are already in an unfortunate position in society.

An example of these kinds of practices from the Netherlands is the condition of compulsory job application in order to receive unemployment welfare. To fulfill this condition an unemployed individual has to apply approximately four times a month to a job. He should also keep the evidence of his job applications and sent them to the UWV, who check if the individual fulfilled the job application condition(UWV). This practice is problematic because it expresses the attitude from society that the unemployed are unwilling to work instead of unable to work. This expresses a major distrust from society to the unemployed and implicitly expresses an accusation of laziness. Therefore, I think the job application conditions express a very humiliating attitude to the unemployed.

Of course, one might argue that this attitude is condescending, but also right because it is simply the truth that most unemployed people are just lazy. Even though I highly doubt this is true, it might be true to some extent. I admit that it is debatable to what extent people are unemployed because of laziness. However, even if it is true that most unemployed people are unemployed because of laziness, the argument still stands. It is still condescending when society treats people who are lazy like they are lazy. And it is also still detrimental for people's self-respect to being treated like they are lazy, even if they are. Therefore, even though the condescending attitude expresses an assumption that might be true, it is still condescending. To avoid any misconceptions, I am not arguing that the job application condition in the Netherlands is necessarily a bad thing. There could be other ethical

considerations that outweigh the condescending attitude expressed by the job application condition. However, my point is that the job application condition is a good example of how a policy measure that could be just in a distributive sense can still express a condescending attitude which is harmful to people's self-respect.

Exclusion of the severely disabled

The third and most important problem is that a justice-only approach excludes the severely disabled from the scope of distributive justice(Denier 2007). In the remainder of this chapter I will discuss this problem. I will start by discussing Nussbaum's critique on Rawls' conception of the person, which is at the basis of Rawls' contract theory. Subsequently, I will discuss how Rawls' conception of the person leads to the exclusion of people who are in a state of dependency from the basic structure of society. After that, I will explain how Rawls' conception of the person leads to the problem of excluding the severely disabled from health care in Daniels theory of just health care.

According to Nussbaum the problem that leads to excluding the severely disabled from the scope of justice starts right at the beginning of his contractarian approach to justice. In a contractarian approach to justice the parties entering in the social contract are assumed to be "free, equal and independent"(Locke 2014). This idea originally stems from Locke and finds its way through Kant's conception of the person to Rawls. Kant sees persons as free and equal moral individuals and Rawls bases his conception of the person on Kant. Rawls envisages the parties in his social contract to be "fully cooperating members of society"(Rawls 1985: 234). Nussbaum criticizes this assumption. She argues that the way Rawls assumes how the parties in the social contract are is based on a "fiction of competent adulthood"(Nussbaum 2000). In real life, people are often in positions of dependency. This begins right when we are born. The first years we are completely dependent on others. If we grow old, the last years of our lives we are also very often extremely dependent on others. Besides that, even in the period in between people are often dependent on others due to mental or physical states of being. For example, people who suffer from Alzheimer or people with paralyzed legs are very much dependent on other people. But also less severe conditions can lead to temporary dependency on others, such as a broken leg or a depression(Nussbaum 2000).

I agree with Nussbaum that the assumption of parties in the social contract to be fully cooperating members of society over a complete life is false. Rawls is also aware that dependency plays a big role in every day human life, but he still insists that we can deal with these issues later on, and that they should not be dealt with in the basic structure of society. The basic structure of society are the most important political and social institutions of society(Rawls 1980). Examples of what is included in the basic structure are: the political constitution, the legal system, the family and economic regulation(Rawls 1973). The basic structure is the domain of justice because these institutions are central in distributing the primary social goods. According to Rawls the basic structure should be structured according to the fundamental concern of social justice, which is structuring a social contract "...between those who are full and active and morally conscientious participants in society, and directly or indirectly associated together throughout a complete life. Therefore, it is sensible to lay aside certain difficult complications. If we can work out a theory that covers the fundamental case, we can try to extend it to other cases later"(Rawls 1980: 546).

Nussbaum criticizes this view because she disagrees that being a fully cooperating member of society over a complete life is more fundamental to human life than being in a state of dependency. According to Nussbaum the mistake to not include human beings in a state of dependency within the basic structure results from the Kantian conception of the person. Nussbaum's critique mainly focusses on what she calls the Kantian split. The Kantian split is the idea that human rationality and therefore also human's capacity for morality is separate from the natural world. Human beings are split in the sense that they are both 'animal dwellers' in the natural world and rational beings in the non-natural world. With 'animal dwellers' Nussbaum means de bodily aspect of human beings. According to Nussbaum this split is wrong for several reasons(Nussbaum 2000). I will not discuss all those reasons here. Rather I will focus on a reason Nussbaum gives which particularly helps in understanding why Rawls sees fully cooperating members of society as the fundamental concern of justice. The reason is that the Kantian split makes us think of ourselves in terms of self-sufficient individuals because our ability for rationality and morality is seen separate from our animality. As a result, we learn to ignore the fact that our capacity for rationality and morality is closely tied to the conditions we are in, in everyday life. For example, infants, old people and diseased people often lack a full capacity for rationality and morality. This fact is

ignored at the basis of Rawls's theory of justice. In Rawls' contract theory people are assumed to be competent adults who are indeed self-sufficient and have only to gain by the social contract because they enter in a mutually beneficial relation(Nussbaum 2000). This has several implications. Animals, for example, cannot enter the social contract because they cannot enter in a mutual beneficial relation with other parties in the social contract. Therefore, they fall outside the scope of Rawls' and Daniels' conception of justice. This does not mean that we can do whatever we want with animals. There are still other values to which we can make an appeal to protect animals, just not to justice. A similar argument could be made about people in a dependent state of being. The focus on mutual beneficial relations should then result in an exclusion of dependent people from the social contract. Dependent people cannot enter in a mutually beneficial relation and therefore fall outside the scope of justice.

I agree with Nussbaum that the aspect of dependency should not be dismissed as not fundamental to human nature. The part of life in which people are in a state of dependency seems too important to human life to add in a later stage of a theory of justice. Also, intuitively, it seems very strange to exclude specific groups of justice because they cannot enter in a mutually beneficial relation. Nevertheless, it might still seem that the assumption is just an innocent simplification necessary to be able to find the right principles of justice in a society. Maybe Rawls is right when he says that the needs of dependent people can be included in a later stage of creating a just society. However, when applying Rawls' contractarian approach to health care it becomes clear that this is not the case. In the next paragraphs I will discuss Daniels approach to just health and how his theory gets into trouble with dealing with the severely disabled because he relies on a Rawlsian conception of justice.

Daniels connects his theory about just health care to Rawls' theory of justice by making health care a part of the primary social good 'opportunity'. Since Daniels connects his theory about just health care with Rawls' theory he also relies on Rawls' conception of justice and the conception of the person on which it is based. We can see this in Daniels' conception of health. In answer to the question 'what is health?' Daniels writes that we should focus on normal species functioning(Daniels 2007). This seems a logical step in the light of Rawls' contract theory because people who are functioning normally can enter in a mutually

beneficial relation with the rest of society. Daniels' focus on normal species functioning allows him to discriminate between needs that should fall under a just distribution of health care and needs that should not fall under a just distribution of health care. However, in doing so Daniels unintendedly also excludes other groups from the just distribution of health care. If the sole focus of health care is to bring people to normal species functioning, what should we do with the terminally-ill, the chronically ill and other groups who cannot be brought to normal species functioning? The focus on normal species functioning does not provide us with an answer. Therefore, we should conclude that the severely disabled[1] are not included in Daniels' theory of just health care(Denier 2007).

Three strategies to solve the problem of excluding the severely disabled

Daniels is aware of this problem and tries to solve it. I will discuss three strategies here in which Daniels' tries to solve the problem of excluding the severely disabled and argue why I think they all fail. In the first strategy, Daniels claims that even though the severely disabled fall outside the scope of justice, we can still include them in our health care system arrangements by making an appeal to another value. For example, Daniels mentions beneficence and charity as possible values to regulate health care for the severely disabled(Daniels 2007: 62). I will argue that this strategy fails because it neglects the common-sense intuition that we have a duty to take care of the severely disabled and it expresses a condescending attitude.

The second strategy is that we should alter or extend the theory in such a way that we can deal with the exceptionally hard cases of justice in a later stage of developing a theory of just health because otherwise it would distract too much from creating the right core of just health care. This strategy is in the spirit of Rawls' who argued that unusual and practical problems can be dealt with in a later stage and should not distract from the fundamental case of justice, which is a mutually beneficial social contract(Rawls 1980). Nevertheless, this strategy fails for two reasons. Firstly, as I have already shown using Nussbaum's argument, being in a state of dependency is much more common than suggested by Rawls and Daniels. And secondly, Daniels' theory of just health is already an extension of Rawls' theory of justice and it still postpones dealing with the severely disabled. It seems very doubtful that

[1] In the remainder of the paper I will call the terminally-ill, chronically-ill and other groups who cannot be brought to normal species functioning the severely disabled.

an extension could include the severely disabled in a Rawlsian conception of justice without being theoretically inconsistent.

The third strategy consists of dropping the Rawlsian conception of justice as the basis of Daniels' theory of just health. Daniels argues that his theory of just health care could also rely on a luck egalitarian conception of justice instead of a Rawlsian conception of justice. In basing his theory of just health on a luck egalitarian conception of justice Daniels can drop the notion of normal functioning from his theory and thereby circumventing the problem of excluding the severely disabled(Daniels 2007: 62). I will argue that this strategy fails because of two problems. Firstly, a luck egalitarian approach to health care would be too inclusive in which health care needs should be met because of justice. And secondly, a luck egalitarian approach to justice would include a notion of personal responsibility for your own health, which is very problematic for various reasons.

Appealing to another value than justice

The first strategy is a strategy Daniels himself suggests. However, Daniels never fully developed this strategy. He mentions only briefly that where health care is generally inefficacious we need another value to deal with people who cannot be brought to a level of normal functioning, like beneficence or charity for example(Daniels 2007). This means that only the people that can be brought to normal species functioning are the concern of justice. People who cannot be brought to normal species functioning should depend on other values to receive health care.

Why charity is not appropriate

As a philosopher I am the last to say that a common-sense conception of justice is necessarily the right one. However, I do think that if the meaning of a concept in philosophical debate strays to far from its common sense meaning it is usually a bad sign. I think it is safe to say that most people would find it strange that we have less duty towards helping the severely disabled than towards people who can be brought to normal species functioning. In contrast to where his theory leads, Rawls himself shares this intuition when he says "we have a duty towards all human beings, however severely handicapped"(Rawls 2001: 176). It is not my aim here to construct a definition of what the common-sense conception of justice is and then argue that it is very different than Rawls' and by extension Daniels' conception of justice. Rather, I want to highlight one feature of the concept justice

which I think is very common-sense and then show that Rawls' conception of justice is inconsistent with it.

Many people feel that justice is closely connected with a sense of duty. This sense of duty is not apparent or less self-evident in charity, which has been proposed by Daniels to arrange health care for people who cannot be brought to a level of normal functioning. Daniels names charity as a possible value to govern health care for the severely disabled. Nevertheless, in daily life most people think about acts of charity as good acts, but do not necessarily feel obliged to do them. One might object to this that most people have a sense of duty to do at least some acts of charity when they are in a position in which they can afford to do so. However, to this I would object that having a sense of duty to do some acts of charity is very different from the sense of duty that is related to justice. With justice, we do not feel like we have to do some justice. We rather feel that we have the duty to act according to justice whenever we can.

I think that arranging health care for the severely disabled based on charity could lead to very disagreeable and counterintuitive practices in society. To illustrate this, I will sketch an example in which health care for the severely disabled is funded through means of charity:

In the Netherlands it is common practice that charity organizations go from door to door with a collecting box. These organizations all have a specific goal for which they collect money. Some examples of goals they pursue are: Animal protection, assistance in international disasters, promoting human rights in other countries, organizing health care for developing countries and investing in research for hard to cure diseases. On the one hand, most people would view these goals as worth pursuing and think it is good that there are collecting boxes for them. On the other hand, almost nobody would feel a duty to give to every collecting box coming at their door. Now imagine that in the Netherlands basic health care through national insurance is only mandatory for people who are functioning in such a way that they contribute to society over their course of life. People who cannot pay the premiums of the national insurance scheme receive compensation from the government.

Individuals that cannot function in such a way that they contribute to society over their course of life are excluded from the mandatory national insurance scheme. They can still voluntarily join in a private insurance scheme, but the premiums for the private insurance

scheme will be much higher than the mandatory scheme. The reason for this is that due to their nature of being disabled in such a way that cannot be cured, they are expected to make much more health care costs because long-term care is often quite expensive. Also, the government will not compensate people who are not able to pay the premium of the private insurance scheme. This results in a vulnerable group not having access to basic health care. However, luckily there is a collection box for this group of people and out of charity almost every year enough people donate so that almost every severely disabled still can get access to enough basic health care. How grateful the severely disabled must be!

There are two important things to notice in this example. Firstly, people who cannot function in such a way that they contribute to society over their course of life are excluded from government regulations aimed at securing basic health care for its citizens. The reason for this is that governments have an obligation to act in accordance with justice, while charity is optional for governments and of minor importance. An example of this is how small a fraction of the national budget governments usually spends on development aid. Secondly, even though the foundation that collects the funds does not succeed in raising enough funds to meet every severely disabled's health care needs, the severely disabled still should be grateful for every health care they do receive. This expresses a condescending attitude and leaves the impression that people who cannot be brought to a level of normal species functioning are some kind of second-class citizens.

Why beneficence is not appropriate

According to Beauchamp beneficence includes all actions that promote the good of other persons(Beauchamp 2016). Beneficence is different from charity in the sense that some acts of beneficence are morally obligatory, whereas this is never the case with charity. Beneficence is also slightly different from benevolence in the sense that the former is concerned with actions that benefit others and the latter refers to the virtue of being disposed to act to the benefit of others. According to Beauchamp the beneficence is best understood as a continuum which runs from acts that are strictly obligatory to acts that are not morally required and exceptionally virtuous(Beauchamp 2016). There are acts of beneficence that most people feel are non-obligatory, such as helping a lost stranger in a city, and there are acts of beneficence that most people do feel are a moral obligation, such as saving someone who is drowning in a pool. Daniels could argue that arranging health care

for the severely disabled is an act of moral obligatory beneficence. However, arranging health care for the severely disabled based on beneficence runs into a different problem. By basing health care arrangements for the severely disabled on beneficence Daniels places health care for the severely disabled in the domain of morality, which is outside the political domain in Rawls' theory. Arranging health care for the severely disabled based on beneficence is an act of the 'good' and not an act of the 'right'. Therefore, in a Rawlsian society beneficence should not have a place in designing the basic institutions in society. This way, arranging health care for the severely disabled becomes an afterthought and reliant on people acting in accordance with their moral obligation. It is not the duty of the government to arrange health care for the severely disabled, instead it is the duty of every individual to arrange health care for the severely disabled. When, health care for the severely disabled is arranged through beneficence instead of justice it expresses that the severely disabled are of a second order and less fundamental concern. According to Rawls, the 'right' is more fundamental than the 'good' (Rawls 1973). Therefore, we should conclude that in arranging health care for the severely disabled through beneficence the health care needs of the severely disabled are of a less fundamental concern than the health care needs of others. I think this still expresses a condescending attitude towards the severely disabled.

The sense of duty connected with justice is why I think it feels strange to say that people who cannot be brought to a level of normal functioning should make an appeal to a different value than justice to receive health care. By saying that people who cannot be brought back to a level of normal functioning should appeal to a different value we say that we do not necessarily have a duty to arrange health care for them, or that we have less a duty to arrange health care for the severely disabled than for others. This seems very much in contrast with the common-sense intuition that we have a duty to care for the severely disabled.

Nussbaum's objections

Nussbaum also reaches the conclusion that we should not arrange health care for the severely disabled with other values than justice, although she uses different arguments. According to her it seems very strange that in Daniels' theory the most severely disabled in society are not a concern of justice, while this seems very much an issue of justice within liberal-egalitarian theory. Nussbaum offers three important liberal-egalitarian intuitions why

including severely disabled people into justice should be at the heart of a liberal-egalitarian theory. Firstly, a liberal-egalitarian society should at the very least be a society that offers decent life chances regardless of birth or race or sex or disability in areas including health, education, employment and political participation. Secondly, these decent life chances should be distributed equally. No groups should be treated as second-class citizens on the basis of, for example, race or sex and also not on the basis of disability. And thirdly, treating no group as second-class citizens is not only important from the perspective of equality but also from the perspective protecting people's self-respect. Rawls' writes that the social basis for self-respect is the most important part of the primary goods. This means that citizens should have their self-respect protected as much as possible by social institutions. Treating a specific group as second-class citizens is very harmful to their self-respect(Nussbaum 2002). I agree with this intuition and it seems that Daniels does so as well(Daniels 2007: 62). Therefore, it seems very strange that Daniels proposes to appeal to a different value than justice when health care for the severely disabled is concerned.

Extension instead of another value

The second strategy to deal with the exclusion of the severely disabled is to extend or alter Rawls' and Daniels' theory in such a way that they can include the people who cannot be brought to a level of normal species functioning inside the scope of justice. This is the strategy that Rawls initially proposes. According to Rawls, "...the fundamental problem of social justice arises between those who are full and active and morally conscientious participants in society, and directly or indirectly associated together throughout a complete life. Therefore, it is sensible to lay aside certain difficult complications. If we can work out a theory that covers the fundamental case, we can try to extend it to other cases later"(Rawls 1980: 542). According to Rawls we first have to work out a viable theory for the normal range before we should think about dealing with the hard cases, such as arranging health care for the severely disabled.

Daniels' also states that we should worry about these hard cases in a later stage. However, this is problematic for two reasons. Firstly, as I have argued earlier using Nussbaum's arguments, these hard cases are no mere exceptions, they are a fundamental part of human life. Secondly, I find it very surprising that Daniels' seems to think that care for the severely disabled should be worried about in a later stage of developing a theory of justice since his

theory is already an extension to Rawls' theory which is especially concerned with health care. Therefore, it seems strange that instead of an answer to the pressing question of 'how to deal with the severely disabled?' Daniels' proposes still the same strategies that Rawls originally proposed: Appealing to another value or adding an extension in a later stage of the theory. However, as Nussbaum states, it is highly doubtful that an extension would work since Rawls does exclude people who are not functioning normally from the beginning of his theory. As I have stated earlier, Rawls' theory excludes dependent people because he starts his contract theory with individuals who pursue their own interest in a bargaining position based on mutual advantage(Rawls 1973). And thirdly, a way of altering the theory to include the severely disabled has already been tried and failed. This way of including the severely disabled into the theory involves governing health care for the severely disabled directly under the difference principle. This means that health care should be distributed in such a way that the most disabled are the best off. However, this strategy is dismissed by Daniels himself because it would drain away all health care resources to a very select number of people. It is very likely that the health care needs of the worst disabled are so expensive that even if all resources where distributed according to the difference principle the most disabled would only receive minor improvements in health compared to all the health care needs that could have been met with a less egalitarian distribution(Daniels 2007).

Luck egalitarian conception of justice

A third strategy Daniels' could use to avoid excluding the severely disabled, is to rely on a luck egalitarian conception of justice instead of a Rawlsian conception of justice. Although Daniels does not mention this strategy explicitly himself when he is faced with the problem of the severely disabled, in another part of his book he argues that his theory could also rely on the luck egalitarian conception of justice developed by Arneson and Cohen(Daniels 2007).

In Arneson and Cohen's luck egalitarian approach, justice requires us to compensate for every deficit, either in welfare or opportunity, which is no fault of our own. As a result, in health care people should be compensated for any disadvantage they have compared to other people which can been treated in health care(Arneson 1988; Cohen 1989). This would mean that Daniels should drop the notion of normal species functioning from his theory and instead base his approach to health care directly on protecting equal opportunity. However, by dropping the notion of normal functioning from his theory Daniels' also loses his way to

discriminate between which health care needs should be met and which not. Instead Daniels' should rely on the distinction between option luck and brute luck to discriminate between which health care needs should be met and which not. Brute bad luck is bad luck which results from no fault of your own. A person cannot influence his own brute luck. Therefore, people cannot be held responsible for inequalities resulting from differences in brute luck. An example of brute bad luck is when you become ill because of a genetic condition. As opposed to brute luck there is option luck. Bad option luck is bad luck resulting from your own choices. In luck egalitarian theory you are held responsible for your own bad option luck(Arneson 2013). An example of option luck is gambling. If person A goes to a casino to play roulette and bet all his money on red, it is his own decision to put himself at risk. Because person A had a choice whether to take the risk, we are talking about option luck. In luck egalitarian theory society has no obligation in compensating bad option luck. Only health care needs that are the result of brute bad luck should be compensated.

Like Rawls' conception of justice, a luck egalitarian approach also focusses on equal distribution of opportunity by making use of the difference principle. According to Rawls' difference principle we should distribute the primary social goods in such a way that we have the best possible distribution for the least well off(Rawls 1973). However, the luck egalitarian interpretation of the difference principle is slightly different than Rawls's. According to Arneson and Cohen Rawls' interpretation of the difference principle does not correct for al morally arbitrary inequalities in society(Arneson 1988; Cohen 1989). In Rawls' theory of justice, the natural distribution of talents and skills are viewed as a baseline against which we judge fair competition for jobs and offices. Talents and skills are natural goods, and therefore fall outside the scope of distributive justice(Rawls 1973). Arneson and Cohen argue that the natural distributions and talents are the result of a 'natural lottery' which is an example of brute luck and therefore morally arbitrary. Thus, talents and skills should fall within the scope of luck egalitarian distributive justice.

In Daniels' theory of just health the special moral importance of health care stems from the fact that health care contributes to equal opportunity. Health care should protect people's 'fair share of the normal opportunity range' in constructing a health care system(Daniels 2007). This seems like a good fit with luck egalitarianism, since they are also after protecting

equal opportunity. Also, health care needs are often the result of brute bad luck, which is precisely what luck egalitarians want to compensate for.

However, Daniels admits that there are some important differences between his original Rawlsian approach and the luck egalitarian approach when concerned with health care. He writes that "Arguably these points of divergence are more important than the point of convergence I want to emphasize"(Daniels 2007: 72). The points Daniels' refers to are that a luck egalitarian approach to health care is too inclusive in determining which health care needs should be met and that a luck egalitarian approach allows for personal responsibility to be an important factor in deciding in which health care needs should be met. I will argue that these points of divergence are indeed very problematic.

Luck egalitarian approach is too inclusive

The luck egalitarian approach requires that any deficit in welfare or advantage resulting from no fault of people's own should be compensated. This results in a much more expansive view of what justice requires from health care than a focus on normal functioning. This is problematic since a more expansive view on what just health care requires might be very disagreeable to most people. At first glance it might seem that the luck egalitarian approach requires us to expand health care to much more than only pathologies. This could, for example, mean that justice requires us treat somebody who is short with growth hormones, since scientific studies show that long people have an advantage over short people in society(Judge and Cable 2004). Another example mentioned by Daniels is that justice might require us to treat somebody who is shy with psychological sessions because otherwise that person cannot successfully do certain jobs, like for example, being a car salesman(Daniels 2007: 72-73).

Most people would feel that in these cases we would have gone too far in equalizing opportunity in the name of justice. However, according to Daniels it is a bit more complicated than this. Daniels' interprets Arneson's and Cohen's luck egalitarianism in such a way that it is less expansive than I have suggested in the above examples. In the original intuition behind luck egalitarianism as formulated by Arneson as equal opportunity in welfare or advantage, Arneson means that ever person should have "an array of options that is equivalent to any other person's in terms of the prospects for preference satisfaction it offers"(Arneson 1999). Daniels' interprets this in the following way. "Imagine that we view a

person’s life as a decision tree in which all possible life histories are represented. Equal opportunity for welfare obtains if each person’s best path on the life tree ex ante has the same expected payoff in preference-satisfaction (or advantage)”(Daniels 2007: 73). What Daniels means by this is that a person cannot simply say: I prefer this path, but because of trait x I cannot follow this path, therefore I need to be compensated for trait x. Thus, the example of ‘I want to be a car salesman, but I am too shy’ does not qualify for compensation in Daniels’ interpretation of luck egalitarianism. Instead, a person only qualifies to be compensated when his best possible path in terms of welfare and advantage is obstructed by some form of brute bad luck.

Nevertheless, even though a luck egalitarian approach to just health care does not necessarily require us to treat every deficit which keeps people from doing better if it was modified, we can still say that the luck egalitarian approach is much more expansive in covering health care needs than a focus on normal species functioning. In Rawls’ and Daniels’ theory a baseline of talent and skills is treated as a given. The difference between people resulting from differences in talent and skill are only indirectly and partly mitigated by Rawls’ difference principle(Rawls 1973). In rejecting this base line, the luck egalitarian interpretation of the difference principle will result in a much more rigorous compensation in society. Also, Arneson states that there is no privileging one kind of deficit over another when it comes to compensating for brute bad luck. Deficits in skill or talent should be treated the same as deficits resulting from disease or disability(Arneson 1988). The above point shows that if Daniels were to base his theory on a luck egalitarian approach a lot more interventions would fall within the scope of just health care, which most people would find very disagreeable. Daniels’ himself admits that a focus on compensating for deficits in opportunity in meeting health care needs is much less likely to inspire reasonable agreement than a focus on normal species functioning(Daniels 2007: 74). This is a disadvantage because an important feature of justice is that every reasonable person should be able to agree with it. When a health care system allows for a distribution of health care which many people find disagreeable it becomes less likely we are on the right track of finding a just distribution in health care.

Personal responsibility

Although the luck egalitarian approach of health care is more expansive over all, in one important way it is more restrictive. In a luck egalitarian approach, health care justice does only require us to compensate for brute bad luck. The distinction between brute luck and option luck would lead to a health care system in which responsibility for your own health plays a much bigger role(Denier 2007). For example, one could ask if justice requires compensating health care expenses for lung cancer patients who smoke on a daily basis. Also, one could argue that justice does not require to compensate people who have an injury because of practicing dangerous sports like snowboarding or parachuting. Or maybe people who do not wear a helmet when cycling should not be compensated either. These examples show how far reaching the implications of a distinction between brute luck and option luck in a health care system can be.

Daniels' theory of just health does not necessarily require responsibility for your own health to be a concern of justice since Rawls' theory of justice does not either. If Daniels was to base his theory of just health on a luck egalitarian approach of justice, he should be prepared to incorporate responsibility for bad option luck in his theory. However, I think that this would severely weaken Daniels' theory since the distinction between brute luck and option luck and how it is tied to responsibility is very problematic. In the next section I will briefly discuss some of the biggest problems the distinction between brute luck and option luck faces.

Firstly, in many cases the distinction between brute luck and option luck is not clear at all(Cappelen and Norheim 2005). To illustrate this point, imagine the following case:

Person B, a forty-year-old who smokes daily, requires treatment for lung cancer. B grew up in a family in which all family members also smoke. When B was sixteen nobody knew smoking greatly increased the risk of getting lung cancer and other diseases. On B's sixteenth birthday B happily smoked his first cigarette, which he received from his parents. B saw it as a sign of becoming an adult and quickly made it a habit to smoke multiple cigarettes a day. When B was twenty-one, it became publicly known that smoking greatly increased the chance of getting multiple illnesses. B also heard this, but decided to keep smoking. When B was in his forties, he was diagnosed with lung cancer.

On the one hand, one could say that this is an example of bad option luck since the patient chose willingly to go smoking. Nevertheless, one could also say that in this case it is not option luck since B did not know the risks of smoking when he started developing the habit. Also, B started smoking when he was only sixteen and got encouraged by his parents to go smoking. One could argue that a minor who was encouraged by his parents to smoke did not really choose himself to do so and is therefore not responsible. However, when B was twenty-one the former arguments for why B is not responsible do no longer apply. B is an adult now, is no longer encouraged by his parents to smoke and fully understands the health risks. But B is addicted to smoking now, which makes it much harder to stop. This leaves us with many questions: Can we speak of option luck when somebody comes from a background in which a certain unhealthy habit is the norm? Can we speak of option luck when somebody decided when he was not an adult? Can we speak of option luck when somebody is greatly influenced in his decision by somebody else? Can we speak of option luck if somebody does not fully understand the risks of his choice? Can we speak of option luck if somebody is addicted? All these kinds of questions need to be resolved before we can design a health care system based on a distinction between brute luck and option luck.

This brings me to the second problem. Even if we have an answer to all these kinds of questions it would still be practically almost impossible to base a health care system on the distinction between brute luck and option luck. I think the example of B also illustrates that to being able to decide if a case is brute luck or option luck it is necessary to know a lot of context. In daily medical practice, practitioners are not trained to distinguish cases of brute luck and option luck and even more importantly, they simply do not have the time to thoroughly examine the context of every patient(Cappelen and Norheim 2005). Of course, this problem could be solved by training people specifically in brute luck/option luck decision making and hiring them specifically for the job of judging between brute luck and option luck. However, this obviously creates another problem: It will greatly increase health care expenses without making any more people better off in terms of health.

Thirdly, there are cases in which most people intuitively would say that justice requires society to compensate even though it is clear that the injury/disease is the result from bad option luck(Cappelen and Norheim 2005). I will illustrate this with an example:

Person C drives with a car to his work every day even though it is only 3 km away. There also is a very safe cycling route to his work. C knows that driving a car more dangerous than taking the cycling route to his work. However, C prefers driving a car over cycling. One day C gets badly injured in a car accident. The accident itself was no fault of C's own.

In this case I think it is safe to say that C got injured because of bad option luck. C chose to drive the car even though he knew it involved a bigger risk than going cycling. However, because the accident itself was no fault of C's own most people would still feel that justice requires us to compensate C for his health care expenses. I think that the intuition behind this is that although C's case is option luck, he did get severely punished for only very small risk taking. This feels unfair.

In this chapter, I have discussed three problems with a Rawlsian conception of justice as a justification for the benchmark of fairness. Firstly, a focus exclusively on justice could lead to a hostile attitude between groups in society. Secondly, a focus on Rawlsian justice could lead to procedural humiliation at an institutional level. And thirdly, and most importantly, a Rawlsian conception of justice leads to exclusion of the severely disabled from just health care. I discuss three strategies that could be used to escape the third problem, which all fail to solve the problem. Firstly, I argued why Daniels' theory of just health cannot rely on another value to arrange health care for the severely disabled. Secondly, I argued why an extension to Daniels' existing theory to include the severely disabled within the scope of justice is likely to fail. And thirdly, I argued why a replacement of the Rawlsian conception of justice with a luck egalitarian conception of justice leads to other problems which are arguably worse than excluding the problem of excluding the severely disabled.

Why we should add solidarity as a justification for the benchmarks of fairness

In this chapter, I will argue why adding solidarity as a justification to the benchmarks of fairness could solve the three problems I discussed in the previous chapter. Firstly, I will discuss more specifically what I mean with solidarity. I am making use of Ter Meulen's conception of solidarity which in the core means to value the relatedness of human beings. Subsequently, I will discuss how solidarity can deal with the problem of creating a hostile attitude, institutional humiliation and the exclusion of the severely disabled by a focus on humanitarian solidarity. Lastly, I will discuss and refute three possible objections against adding solidarity as a justificatory concept to the benchmarks of fairness.

Ter Meulen's conception of solidarity

The concept solidarity can be used in many contexts and it is often not very clear what exactly is meant by solidarity in health care. It is often said that European health care systems are founded on principles of solidarity in contrast to the US health care system, in which solidarity is almost non-existent(Callahan 2011). However, an important problem of using solidarity as a guiding concept for health care arrangements is that it is often not clear what exactly solidarity requires from a health care system. There is no such thing as a benchmark of solidarity, in which health care systems can be evaluated in a step by step way on different aspects of solidarity. Ter Meulen discusses the concept of solidarity extensively using multiple descriptive and normative definitions of solidarity throughout his book(Ter Meulen 2015). I think Ter Meulen's conception of solidarity is best understood in the light of his critique on the Rawlsian conception of justice.

According to Ter Meulen, Rawls conceptualizes the person as a rational independent decision maker only. Rawls does this because it is necessary for his social contract theory to work. In Rawls' theory the fundamental principles of justice are decided in the original position. For the original position to work, participants should have an impartial perspective on society(Rawls 1973). This is the reason why participants in the original position should be behind a veil of ignorance. Because of this focus on impartiality an important part of what it is to be human is being neglected in creating the fundamental principles of justice. Like myself, Ter Meulen argues that this leads to various relevant ethical considerations being neglected(Ter Meulen 2015).

For example, he mentions the view of Larrain according to whom the underlying social processes of dependencies that connect individuals are ignored in the view of men as rational independent decision makers(Larrain 1979). Also, he mentions Elias who does not view human beings as closed individuals with autonomy. Instead he argues that we should see human beings as open, which means that human beings can reach a higher or lower level of autonomy, but never absolute autonomy because human beings are constantly dependent on each other(Elias, van den Bergh, and Godschalk 1971).

It is from this view of human beings that Ter Meulen criticizes liberal theories like Rawls's. The critique on liberal theories is that they ignore "the moral, and particularly relational, commitments between individuals" (Ter Meulen 2015: 92). Commitment and support of others can be understood as a value in itself without appealing to something like mutual benefit. The concept of solidarity is built on this idea and expresses the idea of commitment to support others as a value in itself. In short, solidarity values the relatedness of human beings.

This way of defining solidarity is somewhat different than how solidarity is mostly used in the political context of most modern welfare states. For example, income solidarity and risk solidarity are often mentioned in political debate. Income solidarity is the idea that those with the highest income pay proportionally more for health care than those with low income. Risk solidarity is the idea that those who have less risky lifestyles on average pay for those with riskier lifestyles. However, these forms of solidarity are what is often called interest solidarity. Interest solidarity is derived more from a sophisticated self-interest than the genuine commitment to benefit another human being. Because interest solidarity follows from shared utility or a common interest it is not surprising that this form of solidarity can also be seen in a justice-approach to health care(Ter Meulen 2015). In Daniels' benchmarks of fairness income and risk solidarity are also represented. For example, benchmark five, which deals with reducing inequality in financing according to ability to pay, clearly express income solidarity. Also benchmark five carries the principle in it that health care premiums should not be based on risks of getting an illness, which expresses risk-solidarity(Daniels et al. 2005). These examples show that the benchmarks of fairness do lack all considerations of solidarity completely.

However, interest solidarity is not the kind of solidarity Ter Meulen has in mind when he criticizes the justice framework. He agrees with Jaeggi, who says that solidarity is not a shared utility or a shallower common interest of a coalition(Jaeggi 2001). Even though solidarity can be formed and grow because of a common interest, fate or goal it is not just there because of the common interest. The relations that grow in such a case have value in itself. This is what separates relations of solidarity from a coalition. One does not just switch sides when his own individual interest does no longer align with the group he/she shared a common interest with. The relations with other people in the group still have value to the individual because he feels connected to them.

Humanitarian solidarity

Instead of interest solidarity Ter Meulen calls for humanitarian solidarity to guide the arrangement of health care systems. Humanitarian solidarity is based on the "identification with the values of humanity and responsibility for the other"(Ter Meulen 2015: 172). This means that with the recognition of personhood of another human being there also comes a responsibility to care for other human beings when they are threatened by circumstances beyond their control. This responsibility entails that we should take part in protecting those who cannot protect themselves anymore. Because humanitarian solidarity is based on a shared sense of value of humanity it goes beyond self-interest. According to Ter Meulen humanitarian solidarity is very important and should never be abandoned in favour of rational self-interest. In practice, humanitarian solidarity is mostly concerned with the vulnerable groups in society(Ter Meulen 2015). This is not surprising, because as I have argued earlier, this is exactly where approaches based on self-interest often fall short. I agree with Ter Meulen that we need humanitarian solidarity to include vulnerable groups in our health care system in such a way that it does not create a hostile attitude towards the vulnerable groups and leaves their self-respect unharmed. To see why, I will show how Ter Meulen's conception of humanitarian solidarity could solve the three problems with Rawlsian justice I have discussed in the previous chapter.

Firstly, an increase of humanitarian solidarity in society can help us to decrease the hostile attitude that could grow in a health care system governed by principles of justice only. Promoting humanitarian solidarity could help in creating more understanding for the vulnerable groups in society and helps us to see people who have a claim based on justice

not only as people that drain societies' resources away. By promoting humanitarian solidarity besides justice, the focus shifts from a language of rights and duty's that can be enforced to a language of helping those who are in need because of our shared responsibility take care of those who cannot care for themselves. Because humanitarian solidarity is not ultimately based on mutual benefit it expresses a more genuine commitment to aid the other for the sake of the other than justice does. This genuine commitment to help the other should be seen as a counterbalance to the pursuit of self-interest justice proposes.

Secondly, the genuine commitment to aid the other could also help to dismantle humiliating procedures that justice sometimes inspires. In order to receive their rightful share people often have to go through procedures that are designed to discriminate between people who do have a rightful claim on resources and those who do not have a rightful claim. These procedures express a condescending attitude which is harmful to the self-respect of people who are usually already in a vulnerable position. The humanitarian solidarity approach does not focus on what people's rightful claim is, instead it focusses on caring for those who cannot care for themselves. This means that we should be less concerned with making sure people do not receive more or less resources than is their rightful share and more concerned with the wellbeing of those in need. Therefore, the focus shifts from creating procedures that make sure people receive their rightful share, to procedures that make sure people who are in need are being cared for in a way that does not harm their self-respect.

And thirdly, because humanitarian solidarity is especially concerned with the vulnerable groups in society, using humanitarian solidarity as a guiding value in arranging health care systems is a great supplement to include the severely disabled in a health care system based on justice. Because Daniels' theory of just health is based on a Rawlsian conception of justice he has problems with including the severely disabled in health care. The main reason for this is that the Rawlsian conception of justice is ultimately based on mutual benefit. Because humanitarian solidarity is not based on mutual benefit there is no reason to exclude groups who cannot contribute in a mutually advantageous way from health care. In a humanitarian soliditarity approach to health care the needs of the severely disabled are even of special importance because they can be seen as a vulnerable group in society. Therefore, the focus

of humanitarian solidarity on vulnerable groups should be sufficient to include the severely disabled in a just health care system.

Objections

The first objection is that solidarity, although an important value, is less fundamental than justice in arranging the basic institutions of society. Justice is about rights and duties everybody has, and this is more fundamental than the obligation to act according to principles of humanitarian solidarity. By arranging health care for the severely disabled with principles based on humanitarian solidarity we still exclude the severely disabled from the scope of justice. Therefore, arranging health care for the severely disabled by principles of humanitarian solidarity suffers the same problem as arranging health care systems by principles based on charity or beneficence. The problem is that arranging health care systems by principles of humanitarian solidarity instead of justice to be able to deal with the severely disabled expresses a condescending attitude.

My answer to this objection is that it is based on a misunderstanding of my proposal to add solidarity as a justification for the benchmarks of fairness. The misunderstanding is that I only add solidarity to the benchmarks because I want to deal with the three problems of Rawlsian justice I have discussed in chapter 2[2]. However, this is only partly true. Another important part of my thesis that is neglected in the misunderstanding is that solidarity takes into account a fundamental part of what it is to be human: To put value on the relatedness of human beings. This part of what it is to be human is neglected in a Rawlsian approach to justice, which results in the basic structure being built on an incomplete view of what it is to be human. Considerations of solidarity should take an equal role in designing the basic institutions of society as justice, since they both represent an important part of what it is to be human. Therefore, solidarity is not just introduced as a value to save Daniels' theory of excluding the severely disabled. Rather, the problem of excluding the severely disabled should be seen as a symptom of a bigger issue, which is neglecting the relatedness of human beings in designing health care systems.

Another objection could be that solidarity cannot be integrated in Daniels' theory of just health care because, like Rawls, Daniels is concerned with giving an account of the 'right' and

[2] Hostile attitude, institutional humiliation and exclusion of the severely disabled.

not the 'good.' According to Rawls' only political conceptions of the good are allowed in his conception of justice. Political conceptions of the good must be capable of commanding an overlapping consensus(Rawls 1973).

Even though I think Ter meulen's conception of solidarity might command such an overlapping consensus I will not argue for that here. Rather I want to point out that even if solidarity fails the test of being a political conception of the good and indeed cannot be integrated in Daniels' theory of just health the objection still does not work against my proposal. It is not my aim to integrate solidarity in Daniels' theory of just health. Instead, my aim is to add solidarity as a justification for the benchmarks of fairness, which up till now have been justified only by Daniels' theory of just health. Therefore, the objection that solidarity cannot be integrated in Daniels' theory of just health care is not harming my proposal.

A third objection could be that adding humanitarian solidarity to the benchmarks could lead to conflicting results with the other benchmarks. Especially because there are now two theoretical justifications for the benchmarks: Daniels' theory of just health and Ter Meulen's conception of humanitarian solidarity. I do think that adding humanitarian solidarity as a justification for the benchmarks of fairness makes it very likely that the benchmarks should be extended with some additional considerations raised by humanitarian solidarity. For example, a benchmark based on humanitarian solidarity might require us to evaluate if a health care system has potentially humiliating procedures in place. With adding solidarity, the benchmarks might become confused and no longer offer guidance in making decisions about health care systems.

Nevertheless, I think this objection also fails. The benchmarks of fairness already tend to create conflicting results. Often a plus in one benchmark can be a minus in another benchmark. However, this is not a problem since it is not the aim of the benchmarks to give a clear 'yes' or 'no' on health care systems. Rather its aim is to provide an overview of all relevant ethical concerns of a health care system, which makes it easier to make well-informed decisions. Therefore, adding a benchmark of solidarity will not lead to more confusion. Instead, it will add to the value of the benchmarks in providing us with additional relevant ethical considerations for providing health care measures. Ultimately, the

considerations raised in the benchmark are almost always conflicting and they always need to be weighed against each other by the decisionmakers when deciding if a certain health care system is fair or not. By adding solidarity to the benchmarks this becomes no different.

Conclusion

In this paper I have addressed the question: Should Daniels' benchmarks of fairness be supplemented with solidarity as a justification of the benchmarks? In answering this question, I have discussed Daniels' theory of just health, which provides the background theory for the benchmarks of fairness and faces considerable problems. These problems stem from the fact that Daniels' relies on a Rawlsian conception of justice. In this paper, I discussed three problems with the Rawlsian conception of justice, on which the benchmarks of fairness are ultimately based.

Firstly, when focusing exclusively on a Rawlsian conception of justice to design the basic institutions in society, we run the risk of creating an atmosphere of hostility between parties who have competing claims of justice.

Secondly, a society designed on Rawlsian principles of justice often unintendedly creates humiliating institutional procedures. These humiliating procedures are in place to discern who has a rightful claim on societies' resources. However, humiliating institutional procedures are very problematic because they are harmful to peoples' self-respect.

Thirdly and most importantly, a Rawlsian conception of justice leads to an exclusion of the severely disabled from health care. The main reason for this is the combination of Rawls' conception of the person and a focus on mutual benefit through social contract theory. Rawls' envisages the parties in the original position to be fully cooperating members of society over a complete life. Of course, Rawls understands that in practice not everybody can be seen as a fully cooperating member of society over a complete life. However, according to Rawls' these are exceptions, which should be dealt with in a later stage of creating a just society(Rawls 1980). Nevertheless, I agree with Nussbaum's critique on Rawls' assumption of envisaging persons as fully cooperating members of society over a complete life. According to Nussbaum, being in a state of dependency is a big part of human life and not merely an exception. Therefore, Rawls is wrong in postponing how to deal with persons in a state of dependency to a later stage of creating a just society. Dependency should be of concern in creating the basic institutions of society(Nussbaum 2000). Because Daniels' relies on a Rawlsian conception of justice he also struggles to include people who are in a state of dependency in his theory of just health care. His notion of normal species functioning as the

goal of health care excludes those that cannot be brought to normal species functioning (the severely disabled) from the scope of just health care(Denier 2007).

I discussed three strategies Daniels' could employ to deal with the problem of excluding the severely disabled, which all fail. The first strategy is that we should appeal to charity or beneficence to arrange health care for the severely disabled instead of justice. However, this strategy is not desirable because it expresses a condescending attitude towards the severely disabled. The second strategy is to extend Daniels' theory of just health in such a way that it includes the severely disabled within the scope of justice. This strategy fails because an extension likely would not work since the problem of excluding the severely disabled originates from a problem with Rawls' conception of justice on which Daniels relies. Also, Daniels' theory of just health is already an extension to Rawls' theory of justice and it still has trouble including the severely disabled. A third strategy is to argue that Daniels' theory of just health is not necessarily reliant on a Rawlsian conception of justice. Instead it could rely on a luck egalitarian conception of justice. To rely on a luck egalitarian conception of justice Daniels has to drop the notion of normal functioning. This would mean that health care would be directly governed under the principle of equal opportunity(Daniels 2007). In luck egalitarianism every disadvantage in opportunity should be compensated for as long it is not a person's own fault(Arneson 1988; Cohen 1989). However, there are problems with this approach as well. Firstly, the luck egalitarian approach to health care requires us to compensate for a much broader set of health care issues than in Daniels original approach to health care with normal functioning. It would include health care interventions of which most people would say that they should fall outside the scope of health care. This is problematic because it means that health care based on a luck egalitarian conception of justice is less likely to inspire reasonable agreement. And Secondly, luck egalitarianism requires us to consider responsibility for one's own health to be a relevant factor in whether a person has a right to be compensated for health care costs. This raises a lot of questions about whether a person is responsible for his own disease which are almost impossible to answer(Cappelen and Norheim 2005).

Because of the three problems with the Rawlsian conception of justice on which Daniels' theory of just health relies I conclude that the benchmarks of fairness should not rely exclusively on Daniels' theory of just health. Instead I propose to add solidarity as conceived

by Ter Meulen as a justification for the benchmarks of fairness. Ter Meulen's conception of solidarity is based on many sociological and philosophical work on both the descriptive and normative meaning of the concept solidarity. At the core of Ter Meulen's conception of solidarity is a recognition of the relatedness of human beings. This is different from interest solidarity, which is the more common way of thinking about solidarity in politics. The difference between Ter Meulen's solidarity and interest solidarity is that the former is not based on mutual interest, while the latter is(Ter Meulen 2015: 172).

When concerned with health care Ter Meulen argues that we should use humanitarian solidarity as a guiding value besides justice when creating health care arrangements. Humanitarian solidarity is based on the "identification with the values of humanity and responsibility for the other"(Ter Meulen 2015), which means that we should take care of another human beings when they are threatened by circumstances beyond their control because of shared humanity. We have a responsibility to arrange health care for those who cannot take care of themselves. In practice this responsibility means that we should especially be concerned with taking care of vulnerable groups in society. A focus on humanitarian solidarity in arranging health care systems can solve the three problems of the Rawlsian conception.

Firstly, taking care of people out of humanitarian solidarity instead of justice expresses a genuine commitment to the wellbeing of the other instead of self-interest. Relations that express a genuine commitment to the wellbeing of the other are far less likely to inspire a hostile attitude than relations based on self-interest.

Secondly, institutional procedures that take humanitarian solidarity into account besides justice are far less focused on making sure that people get precisely their rightful share, instead they should be much more focused on the wellbeing of those who are in need of health care. As a result, procedures should be less harmful to peoples' self-respect.

And thirdly, humanitarian solidarity is especially concerned with vulnerable groups of society. The severely disabled are a vulnerable group. Therefore, arranging health care for the severely disabled is of special concern in arranging a health care system based on humanitarian solidarity.

Lastly, I discuss and refute three possible objections to adding solidarity as a justification for the benchmarks of fairness. The first objection is that by adding the value solidarity as a justification for the benchmarks of fairness we make the same mistake as we would have made by adding charity or beneficence as justification for the benchmarks. Solidarity is less fundamental than justice and therefore it expresses a condescending attitude towards the severely disabled to include them into the health care system because of solidarity. This objection fails because solidarity should be equally fundamental as justice in designing the basic institutions of society. Solidarity puts value on the relatedness of human beings, which is a fundamental part of what it is of being human. Therefore, arranging health care for the severely disabled by appealing to humanitarian solidarity, the severely disabled are no longer an afterthought.

The second objection is that Daniels, like Rawls, is concerned with creating a theory of the 'right' and not of the 'good'(Daniels 2007). This means that solidarity has to be able to command reasonable overlapping consensus to be able to get integrated in Daniels' theory. However, the concern of this paper is not to expand Daniels' theory with solidarity. The aim is to add solidarity as a justification for the benchmarks of fairness.

And thirdly, adding humanitarian solidarity as a justification for the benchmarks of fairness will create conflicting results in evaluating health care systems in the benchmarks. My answer to this objection is that the benchmarks already create conflicting results. However, this is not a problem because it is not the goal of the benchmarks to provide a 'yes' or 'no' answer. Instead it aims to provide relevant ethical considerations in reviewing health care systems.

Therefore, I conclude that we should add humanitarian solidarity as a justification of the benchmarks of fairness. As I have written earlier it is very likely that the benchmarks should undergo changes in order to fully incorporate all considerations of humanitarian solidarity. This might involve adding extra benchmarks, but it could also mean that existing benchmarks should change to integrate solidarity. I deliberately do not discuss how the benchmarks should specifically change in this paper because deducing principles from humanitarian solidarity that fit the step-by-step approach of the benchmarks is beyond the scope of this paper. Formulating principles of solidarity to add to the benchmarks should involve an in-

depth discussion which deserves a paper on its own. I also think that formulating principles of humanitarian solidarity might be a challenging enterprise because it is often not immediately obvious how solidarity translates to specific principles. However, I think we should be able to formulate good principles through a thorough debate on what exactly humanitarian solidarity requires when creating health care systems.

Also, by adding humanitarian solidarity as a justification of the benchmarks of fairness it is still possible that the benchmarks remain incomplete. I do not want to create the illusion that every potential problem with Daniels' benchmarks of fairness is fixed by adding solidarity as a justification. The benchmarks might still miss relevant ethical considerations. For example, it might be possible that through the lens of a capabilitarian approach to health care systems there are still some points on which the benchmarks might be improved. However, I think that in adding humanitarian solidarity as a justification for the benchmarks of fairness an important step in the right direction has been made.

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