Priorities in Health Care: why search for principles fails

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Priorities in Collective Health Care Provision: Why the Search for Criteria Failed

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Some time ago it happened again. The attention of the Dutch public had been drawn to the fact that a certain expensive medicine of last refuge for treating cancer of the breast and of the ovaries (paclitaxel or Taxol) was not available to all patients with similar relevant indications. Some hospitals did provide it to all those patients on their request, others only up to a certain budget ceiling, and still others not at all. Understandably, a great outcry was the result. A member of parliament interviewed on television declared that parliament should now quickly make the necessary money available so that all patients who needed it could be given access to this particular drug. But, he added, whether or not such expensive drugs which have only a limited beneficial effect should be made available at public expense, was a difficult and recurrent kind of problem. Hence, what we really needed was a 'list of criteria' for making these decisions. I had a feeling of higher-order déjà vu: not only having been in this situation before, but having felt before having been in this situation etc.

One odd aspect of this repeated request for criteria is that in the Netherlands we are supposed to have them already. Government policy claims to implement the recommendations of a committee which some years ago advised the minister of health care on the problem of cost containment.[1] The committee, presided by the well-known cardiologist Prof. Dunning, shared the former government's wish to introduce a general collective insurance system instead of the present two-tiered scheme. But at the same time it advised to end the present situation in which the payment of a fixed premium ensures a person of a (theoretically) unlimited access to physicians and to all health care services prescribed by them. The Dunning-committee recommended the identification of a package of basic provisions which should be covered by the general obligatory insurance, leaving the remainder to individual discretion.[2]

In order to determine criteria for the inclusion of services in the basic package, the Committee argued as follows. The aim of health care is to restore health, so we should first determine the meaning of 'health'. Two common views should be rejected: the 'individualist' conception which identifies health with freedom (being able to do what you want), and the 'medical-professional' conception which identifies it with the species-typical normal functioning of the organism. The first view should be held responsible for the present open-ended character of claims on the system, for it gives the individual person almost full discretion to decide what she needs. The second view leads to professional short-sightedness: it fails to consider the effects of medical interventions on the quality of people's lives. For these reasons, the committee adopts a third, 'community-based' approach, which identifies health with the ability to fully participate in social life.

The committee goes on to recommend that in selecting health care provisions for inclusion in the standard package, four criteria should be used: a provision should be 'necessary' (i.e. for restoring health in the communitarian sense), it should be both effective and cost-efficient, and paying for it out of his

[1] Cf. Dunning et al., 1992.

[2] In this paper I will address the problem of collective responsibility for health care needs in the same form. As a matter of fact the attempt to introduce a national insurance system has been abandoned by the Dutch government in the meantime. But this has not changed the nature of the search for criteria.

own pocket should be a real burden to the individual.

The ‘Dunning-funnel’ has been officially accepted by the Dutch government and by many actors in the area of Dutch health care provision. But as the Taxol-case and so many others in recent years show, decisions in concrete cases about collective health care provision have not really been made easier.[3] It could be argued that the criteria of the Dunning-report are too vague and should be replaced by more informative and specific ones. In this paper I will argue that such a programme would be misguided. A list of criteria which we can simply apply to new cases as they arise, is something which cannot be had at all. What can be determined in general terms is the nature of the discussion we should enter into for each new case, as well as some of the relevant values, and some other generally relevant but hardly decisive considerations. The real hard work of specifying and weighing these considerations has to be done all over again in each new case.

§ 1. Health and its value

Health care is supposed to contribute to our health, so the obvious question to start with concerns the value of health. The Dunning-committee confused this question with the question of the ‘definition’ of health. But, though at least part of the value of health consists in its contribution to people's well-being, their freedom, and the possibility to participate in society, ‘definitions’ which identify health with well-being, freedom or social participation are clearly mistaken, for we may lack any of those goods and still be healthy. You can be perfectly healthy in prison.

‘Wide’ definitions of health are mainly inspired by the wish to broaden the physician's perspective: he should not take a mechanic's view of the aims of medicine. But this motivation already involves committing the committee's fallacy, for it refuses to look beyond health in identifying the ultimate aim of medicine. We should rather insist on the distinction between health and the value of health, and require the doctor to consider the effects of his actions on both, knowing that his expertise, and hence his authority, only extends to the effects on health. If the distinction is not made, the result is an improper extension of the professional responsibility for defining the goals of professional action.[4]

The Dunning-report amply illustrates the point. Against the ‘medical-professional definition’ - a significant misnomer for what really is a biological one - it argues that if you accept this definition, the provision of food will have to be considered to be a form of health care. Of course it actually is; but that does not mean it is a professional task. Secondly, the greater part of the care of elderly and mentally handicapped people would not be a form of *health* care. Indeed it is not, but that does not make it any the less important. It is simply a Dutch peculiarity to bring these forms of care into the same system of financing.

[3] As a matter of fact, the program of applying the Dunning-criteria to health-care services has been silently abandoned. The actual government policy consists in publicly allowing even the most expensive medicines and forms of cure, including Taxol, but at the same time restricting the indications for using them. As a result, the patients and the general public are often unable to distinguish between rationing decisions and decisions of medical need. There are strong political incentives for avoiding explicit rationing: one other basic reason why the search for a decision procedure fails.

[4] The committee follows present orthodoxy in stating that in micro-allocation decisions only the ‘medical-professional’ definition of health is relevant. Only medical criteria are acceptable, quality-of-life judgments are not. But if quality-of-life judgments aren't smuggled into judgments of medical futility afterwards, as usually happens, this position reintroduces short-sightedness: it requires that decisions about medical actions are made in abstraction from their ultimate aim.

Let me assume that we have an intuitive idea what health is, and what it is not. The idea may not be clear enough to allow us to decide all boundary cases (especially in the area of so-called mental health), but that does not matter for present purposes.[5] Knowing what health is, why do we value it so highly?

It is often said that health has no more than instrumental value, but surely that is putting the point too strongly. Good health is something enjoyable in itself, and for that reason not only a cause of well-being, but also a component of it. On the other hand, it is also clearly a causal factor. Health defects tend to cause pain and other forms of suffering which detract from our well-being. The proper use of our limbs is very often a precondition for our being able to do what we want, and equally often a precondition for our being able to do what we are expected to do. Some minimal condition of health makes all the difference between life and death, and hence is the precondition of the enjoyment of every other good. Which of these dimensions of the value of health is relevant for the decision we want to make about the limits of proper collective concern?

§ 2. Health as a condition of freedom

So far, this question has been mainly approached in two different ways, identified by the Dunning-report, and corresponding to the main currents in recent political philosophy (which is, of course, no coincidence).

The first approach is that particular form of liberalism which defines itself in terms of state neutrality. I will call it the neutral approach. It usually focuses on freedom, and in particular on dispositional freedom: not only being able to live your life in the way you happen to want, but having options to choose from. Of course, freedom is a value, and therefore this approach is not 'neutral' in one sense of the word (i.e. value-free). But freedom is also a special value: it does not rank one particular way of living above others, but requires all ways of living, or at least an extensive range of them, to be available for the individual to choose from.[6]

The neutral approach can be specified in several ways. The simplest one is this: whenever a possible improvement of someone's health by any health care intervention will enlarge his freedom, i.e. will give him an option he would not have otherwise, the intervention should be collectively financed. This way of setting priorities is obviously problematic. For if a medical intervention has any positive effect on someone's health at all, it is always possible to imagine one way of life the possibility of which will be enhanced. So nothing which is effective and cost-efficient will be excluded. And suppose the option this person acquires is one which he already knows he will never choose. Then why bother? Why, in particular, trade other ways of improving human freedom for it? The proposal amounts to giving health care provisions a lexical priority over all other conditions of freedom.

So let us rather try to identify a certain number of options (or a particular extension of the required range of options) which should, as far as possible, be made available to all by the collective provision of health care. (If it is impossible to make it available to someone, due to irreparable health defects, should

[5] A narrow definition will capture this intuitive idea better than a wider one. After all, fish and plants and micro-bacteria can be healthy in the same sense of 'healthy' as human beings, and the state of the economy can be healthy in an understandably analogous sense.

[6] The best-known example of a freedom-oriented approach is Daniels (1985). Daniels (1996: 317-8) concedes that his 'fair equality of opportunity' account fails to yield specific solutions to some basic rationing problems.

she, if possible, be compensated for the loss in other ways, e.g. by monetary means? If, on the other hand, some people's excellent health provides them with options beyond the standard, should they be net contributors to this redistribution scheme? I will pass by these questions.) This second specification of the neutral approach is not more promising than the first. Obviously, our problem of identifying the components of the basic package is not solved, if we are not given more information. As long as we do not know how to find the proper extension of the options, we cannot decide whether we can do so in a 'neutral' way at all. Come to think of it, we already know by an a priori argument that it cannot be. For the whole idea of comparing the extensions of ranges of options makes no sense, if we refuse to make any judgments on the importance of options. Freedom is always the freedom to do *x* or to be *y*, so it is impossible to evaluate forms of freedom without evaluating the value of whatever takes the place of *x* and *y*. (Even if it were possible, we would still need a canonical way of identifying separate options, which we also do not have.) If you are enabled to freely choose your professional career, does it extend your range as much as having two legs, or as having one leg? If you are allowed to enter into the competition for the title of Miss or Mister Frisia, is your freedom enlarged to the same extent as by granting you the constitutional freedom of expression? (In particular if you have no opinions to express at all.)[7] There simply is no neutral way of counting options, we cannot avoid considering how *important* it really is to have any of them.

Instead of requiring the range of options to satisfy an extensional criterion, we should require it to satisfy an intensional one, or an ordered series of intensional ones, or perhaps to include a list of specified options which we argue for one by one. But if we conceive of our task in such a way, we obviously have just reformulated our problem without solving it. It does not help to call the components of the basic package 'options of choice', if we are not going to select them by reference to the value of freedom.

There would be a way out of this predicament, if a plausible intensional criterion could be suggested which is neutral in the required way, in so far as it refers to an aspect of the value of freedom. Recent political philosophy suggests this philosopher's stone: the value of autonomy. The concept of autonomy is thought to differ from the general concept of dispositional freedom by being a threshold-concept. Below a certain level of dispositional freedom, the addition of some option does not make you autonomous, and beyond the threshold the addition of an extra option does not make you more autonomous. A thorough evaluation of this idea would require a detailed analysis of the concept of autonomy, but pending this, three comments can be made. To begin with, even if autonomy really *is* a threshold-concept, the threshold is pretty vague. For while we have some clear examples of health care needs, and some of 'mere preferences', there remains a large grey area within which we have got to draw the boundary between forms of care to be financed from collective means, and forms of care not to be financed in that way. Similarly, while we may have some clear examples of provisions which restore autonomy, and some which fail to do so, a large grey area will remain. The second comment is more important: the two grey areas do not coincide. You can be fully autonomous while lacking the use of your legs, but it seems to belong to the hard core of our considered opinions that a medical intervention aimed at preventing an amputation should belong to the basic package. The third comment is even more important, though perhaps less decisive. We know that we do not influence people's autonomy positively by giving them the

[7] Cf. Feinberg, 1980: ch. 1 (but contrast ch. 2); Hart, 1975.

extra option of choosing a new brand of marmelade, and we also know that giving them the option of choosing their own professional career or religious affiliation really *is* relevant. What I want to suggest is that these judgments again depend on judgments of the relative importance of the options involved as aspects of a good life. The matter is somewhat complicated, for it may be the case that (*pace* Raz[8]) the addition of an extra option - an alternative career or religious affiliation - is not valuable in itself, but nevertheless contributes to our autonomy; it seems sufficient that it is the *kind* of option which is valuable: an important dimension of our well-being as a whole. But even these judgments are not neutral ones.

Only one freedom-oriented approach remains to be considered. Sometimes the lack of a condition of freedom has a gobally incapacitating impact: the absence of food and drink, the absence of clothing and housing in conditions of severe cold, the absence of a minimum level of physical security. A life-endangering illness or defect seems an equally clear example. In this way life-saving medical intervention can be clearly and neutrally identified as a 'need'.

Note that this approach need not be freedom-oriented at all. Life is the condition of every positive good, not only of freedom. This serves to underline that we need not specify any particular dimension of the good, in order to appreciate the value of life-saving medicine: the approach really is a neutral one, even if it is not freedom-oriented. It focuses on forms of health care which really are 'all-purpose means', not only means for achieving freedom.

I grant that the approach, taken in this way, does allow us to understand why some cases of 'need' are paradigmatic. However, it will not enable us to penetrate into the grey zone, unless we extend the account in some way or other. It then turns out that many diseases and physical handicaps do not have *globally* incapacitating effects, but rather take away a limited number of options, and only to a limited extent; and that many forms of curing and caring equally restore a limited number of options to a limited extent. Yet intuitively, we are not prepared to exclude all those forms from the basic package. It does not help to say that we want to take into account conditions which, admittedly, are not requirements or components of *all* ways of life, but still are requirements or components of very large and substantial domains of options. This *is* a proper consideration, but not a neutral one. For the concepts of 'large' and 'substantial' immediately confront us again with the familiar problems about extensional and intensional criteria of freedom.

It may seem obvious that at least the value of life-extending measures can always be neutrally identified: is not life the precondition of everything else? But this is not obvious at all, for in these matters we should consider people's life as a whole.[9] If a person of 85 who had a rewarding life and now is unable to do or to enjoy any of the things which made her life rewarding, is not given a life-extending treatment, are we really significantly reducing her freedom? Your answer on this question necessarily depends on your view of the good life.

Finally, one other basic problem of all freedom-oriented approaches should be mentioned: they do not really cover our relevant basic intuitions. For it seems indisputable that one of the aims of the collective provision of health care is to take away or reduce, if possible, forms of severe pain and suffering. And it

[8] Raz, 1986: 378-81.
[9] Callahan, 1987.

is off the mark to suggest that we only want to alleviate a person's pain because it is an obstacle to the exercise of her freedom.[10]

This point is reinforced by another argument. The decision about collective financing which we are considering concerns access to health care. If we are interested in freedom only, then following that decision, we should guarantee to each person the monetary value of the basic package we have decided upon, e.g. as part of the social minimum, rather than guaranteeing the availability of the package itself. For that would simply enlarge each person's freedom. Nevertheless, we are not prepared to do so. We hold ourselves collectively responsible for providing each person with the opportunity to have his basic health care needs fulfilled, not for providing him with a voucher offering a choice between that same opportunity and several alternatives, such as free travelling to Ibiza.[11] The very fact that collective provision is provision *in kind* shows that we believe our duty to be to save each other from suffering, disease and death. We do not think our duty is fulfilled if we only provide our neighbour with the means to take responsible action, if he wishes. So obviously our duty concerns his well-being, not only his freedom.

I conclude that even if freedom is one of the relevant values for determining the extent of the collective provision of health care, it cannot be the only one. We can only imagine that it is, if we mistakenly interpret perfectionist evaluations of the dimensions of freedom as neutral judgments of its extension.

§ 3. The individual and the common good

As we saw, the Dunning-committee itself subscribes to a community-based interpretation of the concept of health as the ability to participate in forms of social interaction. As a definition of health this is obviously mistaken: many other things may encroach upon this ability in addition to health defects, for example gender (as in present-day Afghanistan) or poverty. So let us rather take this alleged ‘definition’ as a normative statement of the aims of health care, or, to be even more precise, of collective health care provision. I said the committee subscribes to it, but actually, this is only what it says it does; on most concrete issues it immediately retreats to the supreme value of individual freedom. It believes, for example, that it is always illegitimate to take a patient's age into account: even for an octogenarian, the value of a prolonged life wholly depends on her own life-style choices. Some people at this age start writing a trilogy or raising a family.

But at one point at least, the committee actually appeals to its own basic principle. This is in discussing the question whether In Vitro Fertilisation should be included in the basic package. Using the first of its so-called ‘sieves’, the committee puts the question in this way: is it really necessary to make IVF accessible to all, given the communitarian aims of the scheme? The answer is: no; and the arguments are: firstly, involuntary infertility does not endanger the survival of Dutch society, and, secondly, it does not interfere with normal functioning in that society either.

These arguments show an ambiguity in the communitarian conception which is not peculiar to the

[10] In a similar way, Postema (1987: 416-7) objects against Feinberg that the prima facie case against criminalization is not that it restricts liberty, but that it imposes suffering and deprivation. Accepting the prevention of suffering as a proper aim of collective health care provision only amounts to a form of ‘pale perfectionism’; cf. Den Hartogh, Introduction, section 2.

[11] This is often mistaken for a form of paternalism. But our concern is with the way you use, not your freedom, but our money; cf. Den Hartogh, Introduction, section 9.

committee. So it will not simply be a form of parochialism to discuss them rather extensively. The first argument is: involuntary infertility does not endanger the survival of the Dutch society. That is true, indisputably. But if at this very moment I am killed by a stroke, that would not endanger the survival of the society either; no individual is indispensable in that sense. Even if all Dutch people were to be killed by a stroke eventually, that would not endanger the survival of the society. But if all Dutch women were involuntarily infertile, that certainly would.

However, I am not primarily interested in the validity of the argument, but in its interpretation of communitarianism. The interpretation is that the health state of the individual is not important because it is valuable to him, but only to the extent that it is valuable for society. My disease is cured, or the cure is paid for, not because *I* have any interest in the matter, but because the community has an interest in me.[12]

This type of communitarianism offends against one of the most basic principles subscribed to by a liberal society: that the individual is always to be treated as an end in itself, and never only as a means. *Of course* the government exists, and exists only, in order to promote the well-being of its individual citizens. It is not only morally mistaken, but incoherent to deny it. For if we do not consider the society to be a separate individual entity on its own, capable of its own satisfactions, but take it to consist of individuals, it is mystifying how you can treat those individuals as a means only. For what end? If my health is only a means to your welfare, how is it possible for your health to be only a means to mine? At the very least, it seems, my interests should count for one in the calculation of the common good. But even this crude utilitarianism is open to the criticism that it is prepared to sacrifice the individual too easily.

I am not presupposing ‘social atomism’. (Who does?) Some goods, e.g. an intimate relationship or the intrinsic value of cooperation for a worthwhile goal, are such that they cannot be enjoyed by individuals separately, but only communally, or even interdependently (my enjoyment being the condition of yours and *vice versa*).[13] Nevertheless, these are the goods of individuals.

It is also true that the government has a special responsibility precisely for the provision of goods which are common or interdependent in this sense: public goods. It has some responsibilities of this kind in the sphere of health care, as for instance the prevention of the spread of contagious diseases. But the main reason that it has a task in this domain, is that it operates as the agent of our solidarity. People should not as individuals have to bear the risks of the possibly crushing costs of illness. But if society cares for my illness for that reason, it apparently cares for me.

Suppose it did not. It is obvious that in that case, it would have a higher interest in the health of some of its members than in that of others. In many cases, it seems, the individual patient's usefulness to others would be insufficient to compensate for the costs of his care. Should mentally handicapped people have a claim to treatment at all? Are people to be assigned places on waiting lists in accordance with the community's interest in their being healthy? Of course, the committee does not really subscribe to such nasty consequences.[14]

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[12] Cf. Callahan, 1990: 110-15.

[13] Den Hartogh, Introduction, section 10.

[14] Neither does Callahan, 1990: 116: ‘[I]ndividual human life is respected for its own sake, not for its social or economic benefits...’; cf. 66, 122, 145.

§ 4. The individual's interest in social functioning

Let me now consider the Dunning-committee's second argument for excluding IVF from collective insurance: involuntary infertility does not interfere with the normal functioning of the individual in society. One may wonder whether being a parent is not a rather normal form of social functioning for adult people. But again I am not so much interested in the validity of the argument, as in the interpretation it gives to the communitarian aim.

This interpetation turns out to be ambiguous. Why is the normal functioning of the individual in society considered to be important? Or rather: to whom? If the answer is: to society, to the others, then we are back with our first form of communitarianism, the one prepared to sacrifice the individual's interest to the common good. But the answer might also be: to the individual himself.

The same ambiguity also plagues the Dutch discussion about so-called social indications for assigning places on waiting-lists to patients. The question is, for instance, whether you are entitled to a higher place because your illness disables you to go on with your professional job. We should ask why this is supposed to be a relevant consideration: because society profits from the work, or because *for you*, carrying on with your profession is an important aspect of a meaningful life?[15]

Suppose we are interested in social functioning as an aspect of the individual's good. That is the second type of communitarianism I want to discuss. In order even to understand this position, we have to know what 'social functioning' means. The Dunning-committee, very laudibly, advocates giving a kind of lexical priority to the interests of people who cannot take care of themselves, e.g. psychogeriatric and other mentally handicapped patients. Can it be said to be our aim to restore or maintain their normal functioning in society? It is perhaps not impossible to say of an Alzheimer patient that he 'functions normally', i.e. as an Alzheimer patient functions. But if all functioning is social functioning, the communitarian approach loses its distinctness. On the other hand, if only some beings and doings are social beings and doings, why should we restrict our attention to them? If we are prepared to interpret the value of functioning as its value to the individual, I cannot see any possible reason for this restriction. As I argued already, it has always been considered one of the most important aims of health care to prevent avoidable pain and suffering. Pain and suffering usually impair a person's social functioning as well, but that is not the main, or at least not the only reason for wishing to shun them.[16]

I do not want to deny, of course, that social functioning is one of the most important dimensions of the good life. For example, I fully agree with Daniel Callahan that the main problem of re-defining the social meaning of old age in our time is to attribute a significant social purpose to it, though I would prefer to do so in somewhat less conservative terms than he advocates. (Perhaps the elderly should not simply aim at passing on a given tradition, but rather take a role in the on-going learning process in which the tradition is enriched and corrected by the reflection on new social experiences.) But it does not follow that this social purpose is the only dimension relevant to the identification of our health care aims.[17]

The two forms of communitarianism I discussed are equally indefensible. Both identify the good that is

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[15] Callahan (1990: 113-4) invokes the same question.

[16] A point which Callahan (1987: 79) fully recognizes.

[17] And certainly not in the way Callahan (1987) proposes. If old age has its own social meaning, it is a basic need of a person to be enabled to pass through this phase of a 'normal life span' as well as through the others. Life's purposes are not 'on the whole achieved' with old age, but only when there has been 'ample time' for the special opportunities of old age as well.

to be promoted by collective health care provisions as social functioning. Either this is valued for its importance to society, which reduces the individual to a means for the well-being of others, or it is valued for its importance to the individual, but then what *is* important to the individual is arbitrarily restricted to one of its dimensions.

This last mistake, as we saw, is one shared by the freedom-oriented approach. The failure of both approaches is mainly due to their *monism*, their search for a common metric for measuring the value of health care provisions. But the criteria they propose, freedom and social functioning, turn out *either* to be empty umbrella-concepts which fail to exclude anything at all, *or* to be selective in unacceptable ways, arbitrarily concentrating on some relevant aspects of the good life and excluding other equally relevant ones: full cognitive functioning, being mentally well-balanced, sexual satisfaction, mobility, commitment to people and commitment to projects, freedom from anxiety, having opportunities for recreation and play, etcetera. The failure of these dominant forms of monism strongly suggests, though admittedly it does not prove, that the relevant dimensions of well-being cannot be aggregated into a common metric at all.[18] In addition, there is the problem that the value dimensions in question all take the form of continuous scales on which no salient cutting-off point or threshold can be identified in advance. As a result, it is impossible, at least for large sections of the relevant scales, to make a decision on priorities by appeal to a single criterion or an ordered set of criteria.

§ 5. Matters of personal concern

It may be possible, however, to enumerate some relatively wide ranging considerations without claiming the list to be anything more than a checklist or aide-mémoire. I will discuss only one example of such considerations.

Which aspects of the individual good are in general taken to be the proper object of collective concern, and why? Let me consider some paradigmatic examples of values which are and values which are not thought to be matters of social care within Dutch society. Other things being equal, life is such a value. Basic education is another, including basic professional training. Suppose on the other hand that someone has to make a substantial financial investment in order to satisfy a basic requirement of his religion (for example a pilgrimage): that would not be accepted as a good reason to subsidize him. Why not? The provision of professional training involves a social interest beyond that of the individual involved: it is better that he should be able to do a socially useful job than that he should live on welfare and feel alineated from society. But I do not think this is the full answer, even if it is part of it: we also care for his individual interest. On what account is this interest to be distinguished from the interest in fulfilling a religious duty? It is not a matter of ‘weight’: clearly the fulfilment of one's religious duty can be at least as important as the fulfilment provided by meaningful work.

One suggestion is that education and life are consensual goods, while religion is inherently controversial. It may be true that ‘religion’, in a suitably attenuated sense - relating your life plan in a meaningful way to the beliefs you hold concerning the nature of the universe and of human life - is

[18] Confirming what Parfit (1984: 493-502) calls the ‘objective list theory’ of well-being, and Scanlon (1993*a*: section 1) calls the ‘substantive good theory’. Examples of such theories include Finnis (1980: chs. 3-4); Taylor (1982); and Nussbaum’s (1992: 214) ‘thick vague theory of the good’. Cf. Maris, ‘The Liberal Arts’, sections 3.3 and 3.5.

generally accepted as a constituent of a good life. But there is no such consensus about the *right* religion. The particular allegiance of some will be judged by others as at least a waste of time and energy, and possibly a preparation for eternal damnation. So even if they accept that these people should be left to their own decisions without interference from others or from the state, why should they be prepared to positively contribute to the opportunity of realizing those decisions?

This may be one of the relevant distinguishing aspects, but it is certainly not the only or the most important one. We do not believe that prophylactic measures, inoculation etc., for people who want to travel to exotic countries, should be included within the basic package, but that is not because some people frown upon such plans.

Other distinguishing aspects are more central. In the first place, it is part of the meaning of religious duty that it is *imposed* on the individual; an element of effort, perhaps even of sacrifice, is necessarily involved. If every Muslim had a claim on his government to be sent to Mecca by airplane on a free ticket, once every decade, that would thoroughly debase the meaning of the pilgrimage. It is true that profiting from an education also essentially involves some effort of your own, but being provided with the opportunity does not.[19]

Secondly, the value of education (and even of life) as a condition of the good life is independent of one's present desires, but the value of a pilgrimage is not. (Or at least this independent value cannot be ascertained from a common point of view.) This is a second sense in which religious values (within our society) are personal ones. It follows that there is only one measure for establishing the real importance of those values: the opportunity costs which a person is prepared to incur in order to realize them. A policy of maximizing or equalizing welfare is self-defeating if only market-behaviour can reveal people's real priorities.

I believe that even these aspects, important as they are, do not go to the heart of the matter, though they point in the right direction. In the final analysis, we can only ascribe priorities to a person when his actions imply the making of opportunity costs. So there should be an element of sacrifice involved, not only because the relevant preferences are essentially preferences for action-types (or for being a certain type of actor), or because otherwise one's true scale of priorities cannot be verified by others, but because otherwise one cannot really *have* such a thing as a scale of priorities. Having personal values requires dedication, and this is not only or primarily a matter of feeling. If one's every wish would be automatically satisfied by a (good or evil?) demon, one would end up being totally indifferent. Only a finite being can have values.

A person's life achieves his own profile only because his personal values are revealed and consolidated by his choices. That is the basic reason why he should be responsible for realizing his personal values.[20]

§ 6. The upshot: social understandings of individual goods

Consider the following list of medical services. In Vitro Fertilisation, circumcision, artificial hearts,

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[19] Cf. the accentuation of the active aspect of well-being in Raz (1986: 305-7; 1994: ch. 1).

[20] The reason is not, as Rawls (1993: 33-4, 185-7) famously argued, that he is free to ‘choose’ his values given the opportunity costs he has to incur in realizing them. If you are able to give up your religion when it becomes too expensive to fulfil its duties, you were never a believer.

homeopathic medicine or alternative medicine generally, physiotherapeutic treatment of sporting injuries, preventive screening programmes for various forms of cancer, home help, transport of patients to hospitals, breast-corrections for psychological reasons, breast-corrections because of back-problems, birth-control, abortion, special homes for the elderly, adaptations of homes for handicapped people, preventive dental care, appendectomy, hip-replacements for elderly people, lung-transplants, beta-interferon, annual vaccination against influenza, standard vaccination of small children (the costs of which only amount to the equivalent of $ 125,-). Which of these facilities should we include in the collective insurance package, and to what extent should we include them? Which of them should be considered health care *needs* and which consumer preferences only?

Something is only a 'need', if it is a need *for x*, so it seems that all we have to do is to identify the *x*, and our problem is solved. But we cannot find one privileged substitute for *x*. Rather, for each addition to the list we have to decide anew which dimensions of the good life, if any, it is relevant to, before we can decide on its 'urgency'. Most of the time we will begin by looking at uncontroversial cases and proceed from there, arguing from analogy or pointing out shared characteristics.

Only two other things can be done in advance: we can identify shared characteristics which are broadly relevant, as I have done in the last section, and we can describe the general form of our problems in such a way that we get an idea of the type of arguments which are relevant to their solution. Is it more important that the patient feels well or that he 'lives in the truth'? How important is it for people to be comfortable with their appearance? Is it better to be well cared for or to be self-supporting as long as possible? Etcetera.

To go back to the example of the Dunning-report: should IVF be included in the basic package? One can argue this way: having children is not one option among others, the importance of which fully depends on one's personal valuational profile; it is, rather, one of the standard components of the good life for (almost) everyone. Even if people, given their life plans, have reason to abandon this component, that is always a sacrifice, whether they know it or not. Or one can argue this way: even if this good is of some importance to most people, its priority depends on personal values. And precisely if it is a good of fundamental importance to you, the financial sacrifice which it requires is no longer so unbearably high for anyone as to endanger (other) basic components. Besides, it is precisely the assumption that having one's own genetically related offspring is essential to the good life which should be challenged: the assumption itself damages more lives than are damaged by non-parenthood. These are arguments of the right type: they appeal to basic aspects of well-being.

I have rejected two lines of argument which could be called communitarian: the appeal to the common good, and the (exclusive) appeal to the individual good of social participation. The line of argument I endorse may be called communitarian as well, but in a different sense.[21]

The first question we have to ask is: what is the relative order of importance (to individuals) of every

[21] Communitarian argument of this type is characteristic of Callahan (1987: 33, 60; 1990: 24-5), but he frequently confuses it with the two other forms of communitarianism I rejected, cf. notes 12 and 15. Even the best representative of the type of communitarianism I recommend, Michael Walzer, is to some extent guilty of this confusion. Every community, he says for example, is always arguing about the specific programmes of mutual provision it should adopt, '[b]ut these are not arguments about individual rights; they are arguments about the character of a particular political community.' (Walzer 1983: 78) I grant that nothing can be identified as a 'need' without reference to common understandings. Even so, those understandings are understandings of the needs of individuals, not of the character of the community. Therefore the arguments are not *about* the character of the community either, even if they express and sustain that character.

new improvement in health that medicine can procure? We do not have to know anything about our society in order to ascertain that it is of the highest possible priority to save the life of a person who is thereby restored to full health as well. But in many cases these judgments can only be made by reference to the meaning of certain ways of functioning within our society. How important is it to be able to do professional work, to have genetically related offspring, to have your life prolonged even beyond the age of 85? There are no general belief-independent answers to these questions.

The second question is: which of these classes of facilities are we prepared to make a matter of collective care? The concept of a ‘need’ itself does not offer much of an answer, because it does not connote much more than a particular degree of urgency. I have proposed to interpret it as referring to conditions and components of the good life that are of fundamental importance, whatever one's individual priority-scale.[22] Once again, some conditions and components of this kind - the absence of globally incapacitating defects - can be identified by reference to basic facts about human existence. But as soon as we enter the grey zone of controversy, we can identify them only by reference to common beliefs.

This, obviously, is not communitarianism in any of the other forms, for I am referring to the needs of individuals, without restricting them to the need for social participation. But whether a good is a need, is not a matter of subjective feeling or individual judgment, but, to use Michael Walzer's terms, of our ‘shared understandings’ of the ‘social meaning’ of the good. The controversy, as he says, concerns the best interpretation of our consensus. And in as far as it cannot be decided by argument, it has to be decided by arbitration. That's why we have politics.[23]

In a way I am only saying that we should care for what we already care for. But this is not quite as empty as it sounds, because it points to a style of argument.[24]

[22] Cf. Braybrooke (1987: 29ff.) on course-of-life needs.

[23] Den Hartogh, Introduction, section 10. For reasons alluded to in note 3, the usual political procedure in democratic societies may not be the one best suited to make this type of decision. In that case, some variation on the Oregon-procedure should be considered: entrusting a committee which is more accessible to argument, and less to lobbying or electoral considerations, with the task of prioritizing facilities, and letting parliament restrict itself to deciding where to draw the line.

[24] The argument of this chapter should not be interpreted as a criticism of the appeal to general considerations in ethics. Rather, the argument allows a plurality of such considerations to be taken into account alongside more concrete judgments in a reasoning process aiming at reflective equilibrium, cf. Beauchamp and Childress, 1994: ch. 1.