Title: Book Review: *Just Enough Health: Theories of Health Justice* by Thomas Schramme

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Thomas Schramme's *Just Enough Health: Theories of Health Justice* [1] is a comprehensive introduction to the topic of health justice, and provides a map of theoretical approaches to guide further reading and reflection. It helpfully locates theories of health justice in relation to conceptual debates about health and disease, as well as theories of social justice. The book includes chapters on global health justice, and the role of a theory of health justice in limiting pathologisation and medicalisation. Either the chapters on specific topics or the book as a whole would be an excellent resource for teaching introductory lessons or courses on health justice. In addition, the book summarises and solidifies a conceptual framework, developed in Schramme's previous publications on this topic (listed on page xi) which will do much to move debates on health justice forward. The final chapter presents an elegant, albeit brief, argument for Schramme's sufficientarian theory that draws upon the resources developed throughout the book.

The argument for sufficientarianism is developed via several distinctions. Some align with each other, while others cut across each other to provide different axes by which to map the conceptual terrain. First is a distinction in how health is conceptualised: negatively as the absence of disease, or positively as something more substantive. In the first two chapters, which provide an overview to the debate on disease and health, Schramme argues that one normative role of a conception of disease is to 'gatekeep' claims to healthcare justice. If we have a way to specify what counts as disease, we can prevent unwarranted expansion of claims, by regarding claims as justified only where disease is present. For this gatekeeping purpose, he argues, a naturalist conception of disease – health as the absence of physiological dysfunction – is most apt. A detailed case for the need for such gatekeeping

is further developed in chapter 6, which presents a discussion of medicalisation, pathologisation and healthisation.

However, Schramme argues (chapter 2) that a theory of health justice also needs a substantive conception of health. Such a theory needs to provide guidance not only on what claims are justified, but on what they justify: how much treatment, and how different claims can be weighed against each other. Schramme canvasses two options for a positive conception of health, as an aspect of wellbeing or as an asset. The former regards health as intrinsically valuable, and healthcare provision as enabling people to attain a minimal level of health. The latter focuses on health as instrumentally valuable, with a role in enabling people to access other opportunities. The positive conception of health regards it as a scalar notion, while the negative, naturalistic conception regards it as a binary.

Next, in the course of introducing the reader to the main approaches to theorising social justice (chapter 3) Schramme emphasises the distinction between comparative and noncomparative theories of justice. Comparative theories, notably egalitarianism, take what is due to any individual to depend on what others have. Noncomparative theories such as sufficientarianism take what is due to any individual to be independent of interpersonal comparisons, and so need to appeal to some other criteria. Comparative theories will typically involve viewing the currency of justice as scalar, while noncomparative approaches will need to set some threshold, suggesting a binary view.

Schramme then maps theories of health justice according to two of these distinctions (chapter 4). The distinction used as primary is that between theories that regard health as an intrinsically valuable aspect of wellbeing, and theories that regard it as an instrumentally important asset. Within each of these kinds of theory Schramme further locates specific views in terms of their focus on a positive, scalar conception of health, or a negative binary conception; that is, in terms of whether they see the goal of just healthcare provision as maximally increasing health, or as aiming at a minimal standard of health. The former is a comparative approach that will tend towards egalitarianism while the latter is noncomparative and tends towards sufficientarianism (although specific theories may combine different elements or be sit in between these focuses). The chapter also provides

discussion of general issues for any theory of health justice such as the use of QALYs and the role of individual responsibility for health.

Schramme's argument for sufficientarianism (chapter 7) begins from the recognition that a health condition is not necessarily experienced as harmful or negatively evaluated by the person who has it, drawing on literature on disability and chronic illness. He argues that we can understand claims that a physiological dysfunction is not harmful to be about *noncomparative* or absolute harm, while still regarding such health conditions to be *comparatively* harmful. Following Schramme's commitment to naturalism, this is to say that any physiological dysfunction can be regarded as a kind of 'harm', as making the person worse off than they would have been without the dysfunction – but only for a non-evaluative sense of 'harm'. The presence of a dysfunction has no necessary normative implications.

This distinction is then extended to thinking about disadvantages and equality of opportunity. A health condition may disadvantage someone comparatively – that is, they are disadvantaged relative to not having had that health condition – but not disadvantage them absolutely. This could be because of a positive subjective assessment as well as how the person is able to manage the condition, including social arrangements that allow such management and/or compensations provided by health care systems. Thus physiological dysfunction is necessary but not sufficient for a health-related absolute disadvantage.

This implies that to identify when there is an absolute disadvantage, we cannot compare someone's situation with that of others but rather need to appeal to some other criterion. For Schramme this is provided by examining the goal of healthcare provision in a welfare state (an argument developed drawing on an analogy with education). The goal, he argues, is to enable everyone to have a minimal level of health, not to enable everyone to be as healthy as they can be. Noncomparative equality of opportunity means that the aim is for everyone to have a reasonable chance of achieving this goal, rather than for everyone to have the same chance. For Schramme, this follows from the view that comparative disadvantages generate no normative content: it is lack of health, with its implications for

both wellbeing and opportunities that is normatively relevant, not that others are healthier (p 113).

Schramme's claim then is that it is absolute health-related disadvantages – harmful dysfunctions – that give rise to valid claims to healthcare justice. The naturalist notion of disease as statistically atypical physiological dysfunction acts as one gatekeeper, but 'harm' conceived noncomparatively provides a further criterion.

Just Enough Health is an impressive volume, considered either as a textbook and teaching resource or as an argument for a specific sufficientarian position. Schramme's argument is compelling: like Daniels' egalitarian theory [2,3] it utilises a naturalist understanding of disease to prevent expansion of healthcare claims, while introducing a further normative criterion derived from a positive conception of health. The latter acts simultaneously as a further gatekeeper and a recognition that not all physiological dysfunctions are (or should be) negatively evaluated. Further, the normative criterion means the theory provides not only guidance on what healthcare justice claims are justified, but on what they justify. Since a harm may be more or less severe or important, it can help point to ways of deciding what level of resources specific claims warrant and how different claims might be weighed against each other.

One point at which the view is likely to encounter objections relates to Schramme's use of the naturalist conception of disease. His theory does incorporate a normative perspective, and in a sense is more fully Boorsean than is Daniels' in incorporating thinking about both only naturalistically identified disease ('theoretical' disease) and when theoretical disease warrants intervention ('therapeutic' disease) [4]. On the other hand, this makes it less clear precisely what work naturalism is doing, and why we may not just appeal to the normative criterion. Schramme is clear that the naturalist understanding of disease acts as a first gatekeeper, a necessary though insufficient condition for claims for healthcare justice: in delimiting the possible scope of claims it plays a role that the normative criterion of absolute harm could not. This role is weakened however by the fact that we will not apply it consistently: we do think it just to provide healthcare resources in some cases of non-disease. This includes examples such as 'treatments' for unwanted fertility as well as

preventative and public health measures. Of course, Schramme recognises this difficulty (p. 115), and suggests that a way forward may lie in recognition that health is only one element of wellbeing and attending to the notion of basic health needs (p. 119-22). This will need further development to clarify the role of naturalism in this theory.

Schramme's richly developed conceptual framework and argument will no doubt generate debate at this and many other points. They do much to move debate forward and further develop sufficientarian thinking about health justice, while providing students with a thorough grounding in the topic.

References

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4. Boorse C. Concepts of Health. In *Health Care Ethics: An Introduction*, eds D VanDeVeer and T Regan, 359-393. Philadelphia: Temple University Press.