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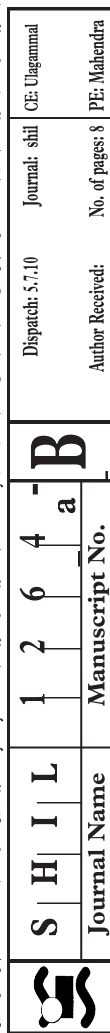
Book reviews

Segall, S. *Health, Luck, and Justice*. Princeton: Princeton University Press 2010 252 pp. $35.00/£24.95 (cloth) ISBN 978-0691-14053-7 (e-Book) ISBN 978-1-4008-3171-5

Over the last thirty years a group of academic philosophers has developed the view that the essence of egalitarianism—what follows from the equal moral worth of persons—lies in neutralizing the effects of bad luck on a person's life prospects; that a society or government showing equal concern and respect means mitigating the disadvantages caused by factors that an individual has no control over. To have any meaning, such a view also requires holding people responsible for the consequences for what they can control or could have controlled including the risks taken. Shlomi Segall is one such 'luck egalitarian' and begins his book by identifying a troubling dilemma that is akin to the proverbial path to hell being paved with good intentions. The dilemma he faces is that if it is right that society should neutralize disadvantages from the natural lottery (genetics, innate intelligence, natural talents, etc) and the social lottery (family upbringing, birthplace, community culture, etc) in order to engender equality of opportunity for individuals, and then hold people accountable for their actions, such a view leads to the harsh and 'counterintuitive' result in the domain of health care; individuals who are ill because of their imprudent choices have to be abandoned. That is, according to luck egalitarian justice, it is right to provide health care to those who need it because they are naturally or socially unlucky but those individuals who are ill and indeed at risk of death because of their own negligence do not have any claims on society for assistance. In fact, imprudent individuals can be seen as avoidably burdening the health system, taking away resources from unlucky individuals, and are unfair to those who at least do try making prudent decisions.

In this outstanding book which exemplifies well the style and methods of analytical political philosophy, Segall sets out to save luck egalitarianism from its inhumane ultimate conclusions in the domain of health care as well as from being rejected more broadly as an approach to social justice. The meanness of abandoning the negligent victim was highlighted by Elizabeth Anderson as one of several weaknesses of luck egalitarian justice in a devastating essay titled, What is the Point of Equality? (1999). In this book, rather than 'biting the bullet' and defending the denial of health care, Segall endeavors to escape the charge of meanness as well as develop a luck egalitarian argument for universal and unconditional health care. In fact, Segall aims to do much more than that by also working through how luck egalitarianism would address social determinants of health and the health gradient, human enhancement technology, devolution of health care services, and global health inequalities. In a short review like this it would be unfair to try to assess the full breadth of Segall's arguments he presents over eleven chapters. I will instead focus on situating the book, how he addresses the primary initial dilemma, and offer a few comments.



In the early sections Segall lays out the tenets of luck egalitarianism and its genesis as a critique of aspects of John Rawls' conception of social justice defined in *A Theory of Justice* (1971). Rawls continues to tower over philosophical debates about social justice, and in relation to health issues, he famously assumed away all disease, disability, and premature mortality in his theory. Norman Daniels, in turn, is famous for modifying Rawls' theory to integrate health issues in his book *Just Health Care* (1985). Roughly, Daniels argued that 'species typical normal functioning' is instrumentally valuable for achieving a life plan

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that falls within a normal range of life plans in a society, and because impairment of normal functioning affects the equality of opportunity for achieving life plans, all citizens should be entitled to health care as part of ensuring equality of opportunity. Daniels has recently modified his theory partly to incorporate the social determinants of health research (2008). Segall believes that luck egalitarianism is the leading alternative to Rawlsian justice and thus uses the Rawlsian/Daniels's argument for distributing health care and the social determinants of health to ensure equality of opportunity as a foil throughout the book. That is, it is Ralwsian equality of opportunity in relation to health care and health determinants versus his own luck egalitarian version of ensuring equality of opportunity, which consists of neutralizing the bad health effects of natural and social factors that one could not be reasonably expected to control or avoid.

Segall criticizes Daniels's fair equality of opportunity argument because it mitigates only social factors and takes naturally caused constraints as given - for denying health care to the elderly, as they have already had their fair opportunity; and for 'leveling down' or wasting potential health of some for the sake of ensuring equality of opportunity of all. While he also criticizes other approaches, the positive position Segall does eventually take is that abandoning the imprudent is the right logical conclusion but that more fundamental or prior moral social commitments such as that of meeting basic needs would intercede to provide care to the imprudent patient. He defends this resolution to the dilemma by arguing that luck egalitarianism is only a part of morality, and that we use various other values to design and judge social institutions aside from fairness. Moreover, this notion of a longstanding or foundational ethical commitment to meeting basic needs includes medical care needs, and makes health care something that cannot be withheld from anyone. This inability to deny anyone basic needs then leads to providing universal health care to all residents within national borders. Nevertheless, where scarce resources force a choice between one who was prudent but unlucky and one who was imprudent, Segall suggests a weighted lottery, slightly weighted in favor of the innocent party. Providing some chance of getting health care is said to provide escape from the meanness objection, but it is ironic that applying a theory that seeks to neutralize bad luck nevertheless leads Segall to rely on a luck mechanism to determine life or death decisions.

I disagree with Segall about the extent to which luck egalitarianism constitutes a substantive theory of justice, and therefore how satisfactorily it illuminates what to do about the issues he focuses on or other troubling health issues facing us today. I also find analytic philosophy particularly exasperating when weaknesses in theories are seemingly solved through linguistic manouvres; the theories and their champions can save face but what wisdom or practical guidance do the moves and counter-moves provide for real world justice? Perhaps the biggest weakness of this otherwise engaging book is that it completely side steps the capabilities approach to social justice. It is clear that Segall is aware of the work of Amartya Sen and Martha Nussbaum, and uses their ideas and quotations at important points in his arguments. But the book misleadingly presents health justice debates as largely shaped by and occurring between Rawlsians and luck egalitarians. It is not insignificant that Sen used physical disability as the illustrative example to highlight what is wrong with Rawls' theory and broader egalitarian thought in his 1979 Tanner lecture on human values before advocating basic capability equality. And Nussbaum has written extensively on moral luck which informs her arguments for basic capability entitlements such as to life and bodily health. The same arguments which intercede here to save the imprudent patient.

Having said all that, there is much to commend about this book. This book nicely integrates and extends various articles Segall has previously published to present a luck egalitarian view on health inequalities. He raises the standard for the burgeoning philosophical discussions on health and social justice and gives us much novel material for further consideration. Graduate students and academics interested in political philosophy and health ethics will find this book interesting and a rich resource. It is clearly written, rigorously argued, and thoroughly engaged with relevant literature. Also, in the age of cheap paperbacks, e-books and pdf files it seems worth mentioning that the book is a beautiful object in itself.

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Cann, P. and Dean, M. (eds),*Unequal Ageing: the untold story of exclusion in old age*, 2009 The Policy Press, Bristol 192 pp. £17.99 (pbk) IBSN 978 1 84742 411 2 £60 (hbk) IBSN 978 1 84742 9

Early in 2010 and in anticipation of the general election in May, the politics of old age in the UK has attracted considerable attention. There was, for example, the brahouha triggered by Martin Amis concerning age and euthanasia. Underlying such debates are the twin questions, 'what do we do with all these old people?' and 'how do we pay for it all?' Anxiety over the wider economic situation has two clear consequences: a rising concern about the future financial wellbeing of younger generations and a popular belief that the generations currently enjoying their old age are lucky. Equity between the generations remains a potent issue.

This book then is timely. It is based on an interesting collaboration between academic researchers, campaigners and journalists, and its origins are not unconnected with the merger of the two largest national voluntary organisations campaigning on behalf of older people, Help the Aged and Age Concern, to create AgeUK.

There are two chapters that confront issues of health. In his introductory chapter, Malcolm Dean discusses the 'grim losses in health' of older people, focussing on age-related disability and poverty. Perhaps to ease a sense of despair, he then quotes Michael Marmot, who contrasts statistics drawn from the 2002 English Longitudinal Study of Ageing on mobility problems in middle age (43 per cent) with the continuing abilities of people in their 80s (of whom 58 per cent report having no difficulties): 'middle age is no paradise; old age is no hell'. Dean then discusses costs and charges in healthcare and social care, and the differential impact this has in relation to the experience of chronic disease.

Anna Coote, the author of a chapter titled 'The health dividend: health and well-being in later life', demonstrates that, despite overall improvements in health in later life, class inequalities have increased over the last thirty years: 'the poorer we are, the more likely we are to be ill in those extra years' (p. 55). Drawing on the research of Hilary Graham, she adopts a longitudinal perspective, claiming that 'poor people's health starts to decline earlier and then gets worse more rapidly'. She makes the case for preventive action 'up-stream' before the need arises for treatment 'down-stream'. She also notes the ways in which older people are offered poorer treatment than younger people due, she suggests, to ageist attitudes of providers, ineffective treatments and debateable cost-related decisions. She then considers how poverty can be tackled and inequalities in health and well-being reduced; turning to legislation on equalities for example, she considers the work of the Marmot review of how health inequalities in England might be reduced.

Other chapters touch on health issues. In Chapter 2, Thomas Scharf provides a case study that uncovers the interplay between poverty, age and health, and he argues that the recession will increase excess winter deaths. Sue Adams, writing about housing, discusses how poor housing leads to poor health and she focuses on how housing can be adapted to meet the needs of age-related medical conditions. Like Scharf she refers to winter deaths, along with how the risk of falls and incontinence might be reduced.

Fundamental to the book is the question of inequality. In his chapter, Alan Walker addresses the basic question 'why is ageing so unequal?' His opening sentence refers to the impact of unequal ageing on older people but like several other contributors, he locates the explanation of this inequality in the trials and stresses of mid-life (pp. 148–9). Only then does he consider inequalities between age groups when he argues that these are due to a systemic failure by British governments to ensure adequate and equitable pensions. In particular, he notes that Beveridge drew heavily upon the 'subsistence-oriented' research of Seebohm Rowntree: 'Hence there was a scientific justification for the political decision to apply a relatively mean standard of living as the norm' (p. 152). In his chapter, Dean notes that as the book was being written, Wilkinson and Pickett's *The Spirit Level* was published. Although he comments upon the significance of their work for health in general it is a pity that it was not possible to discuss in more detail the relevance of this, and in particular inequalities in life expectancy, for age inequalities.

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Paul Cann, Director of Policy, Research and International Development at Help the Aged between 2000 and 2009, is the author of the concluding chapter. He begins by noting progress but regrets that 'big inequalities' remain. He italicises a series of themes: a sure start to later life, joined-up services, an observatory on age, opportunities for an integrated mid-life review, tackling isolation by promoting interdependence, and championing assistive technology, passing and implementing the Equality Bill. Anticipating an electoral victory for the Conservatives, he struggles to find reason for hope.

In summary, the book is primarily about the ways in which older people currently have a raw deal: what is unequal in regard to health are (a) the ways in which the NHS relates to and serves the various age groups, and (b) the inequalities associated with poverty and wealth that persist in later life. It pays some attention to the current mess regarding policies on retirement age and age-related benefits, but it is disappointing that it ignores issues of generational equity. It is clear that, in anticipation of the election, the editors and contributors were attempting to represent the interests of older people and to raise important issues, if not exactly to set a political agenda. Given the volatile outcome of the election, the editors should be encouraged to produce an updated second edition

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Peckham, S. and Hann, A. (eds), *Public Health Ethics and Practice*, The Policy Press:
Bristol, 2009.(hbk) £65 IBSN 978 1 84742 103 6 (pbk) £21.99 IBSN 978 1 84742 102 9

Principlism has been the dominant orthodoxy in the application of ethics to medicine for a generation. Although its original authors, Beauchamp and Childress, have, in successive editions of their text, increasingly acknowledged the relevance of alternative approaches, principlism lends itself so well to the checklist project, of reducing medical practice to algorithms, that it has been hard to displace. If you can tick the boxes of autonomy, beneficence, non-maleficence and justice, then your practice must be ethically sound. In practice, as critics have observed, justice is frequently the least of these and the principlist approach embeds American models of health care, with precedence given to individual choice and self-determination, within what purports to be a universal theory. It is perhaps a mark of the increasing marketization of English health care – although not Scots or Welsh –that this theory has come to have such a strong influence here.

However, the principlist approach has come under increasing criticism from ethicists who are more sensitive to the situation of the developing world, such as Benatar, for its neglect of distributional issues and the poverty of its understanding of the trade-off between individual claims and population benefit. These criticisms are finally being echoed in developed countries, with the rise of public health ethics as a distinctive approach. The role of ethics in public health has been given particular urgency by recent events such as the 2009 influenza pandemic. Although this did not, in the end, prove severe enough to challenge doctors and planners to produce ethical defences for explicit rationing, the threat was sufficiently real to justify a considerable investment in the analysis of the relevant issues.

Peckham and Hann have, then, produced a most timely collection of essays on public health ethics, addressed particularly to the Faculty of Public Health and to the argument that ethics should become a mandatory part of the training of public health specialists. The collection is comprehensive, lucid and well-presented, and will be a valuable resource for courses that may develop. The volume opens with two papers introducing the idea of public health ethics and locating it historically and intellectually. The main ideas are then applied through a number of case studies on specific topics relevant to public health specialists or health service planners, before concluding with two more programmatic chapters – Dawson's caution about introducing a new kind of checklist rather than cultivating the moral awareness of public health actors is particularly important.

Two brief reservations about this otherwise valuable book. First, it is not always clear what is distinctively ethical about the critiques in the case studies, particularly those of health education and the obesity 'epidemic'. How different are they from what medical sociologists might write on the same topics? Could ethics simply be the latest attempt by established medicine to find a tame discipline of the social – a search that has been going on at least since the Todd Report on

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medical education in 1968 and which is almost certainly doomed to failure. Todd provided a huge boost to medical sociology, which subsided as sociologists came to be perceived as an unruly bunch who challenged medical framing of research questions and agendas. The same cycle has been repeated on numerous occasions with different disciplines over the last 40 years. Will ethics – or its new friend, medical humanities – be any different in ten years time, or will it be yet another spurned lover?

Second, and partly related to the above, I was disappointed by the lack of reference to the degree to which ethics might be a substitute for politics. Many of the conclusions here, on what constitutes social justice and on the priority to be given to equality in public health work, are profoundly political but not acknowledged as such. Is the turn to ethics a symptom of the depoliticization of UK politics over the last twenty years? Social justice is presented as a technocratic matter for experts rather than a concern for citizens and social mobilization. Is this another example of the covert paternalism of the consumerist NHS, of the profoundly Foucauldian biopolitics of reconstructing citizens to fit an elite vision, rather than listening to citizens? Could public health ethics be yet another vehicle for disempowerment and the exclusion of citizens from governance?

Nevertheless, this is a book that should be widely read and which should both provoke and shape debate in any context concerned with the future of UK public health, and public health training.

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Duncan, P. *Values, Ethics and Health Care*. London: Sage. 2010. Ix + 157pp. $37.95 (E-book) ISBN 978-1-84920434-7 £60.00 (hbk) ISBN 978-1-41292351-4. £19.99 (pbk) ISBN 978-1-41292352-1.

Values, Ethics and Health Care is billed as something of a 'textbook' or guide to the topic aimed at undergraduate students in the healthcare and allied healthcare professions. Some of the comments included on the publisher's website suggest that it will also be of interest to the postgraduate and/or practitioner. While I have no reason to disagree with these suggestions, the book repeatedly raises a single question: how do we teach values to students of the healthcare professions?

This question or varieties of it are scattered throughout the recent history of medical education, usually appearing under the rubric of teaching the art, in contrast to the science, of medicine. What originated (in their modern form at least) as questions regarding the teaching of a good bedside manner developed into a more specific concern with the teaching of communication skills and then into one of medical ethics and law. Modern research into medical education began in the postwar era and has increased dramatically in volume, purpose and nature between the 1980s and the present day. Running alongside 'curricula' developments has been a trend towards a generalised 'reflective' pedagogical approach. Research into medical education is a diverse endeavour not only in that its authors may be clinical or, increasingly, non-clinical medical educators but also in that they may be operating as medical outsiders and may be working from any number of disciplinary perspectives such as education, sociology, anthropology, history; applied 'empirical' ethics; and psychology, not to mention the various subfields of these disciplines and the increasing practice of interdisciplinarity.

Duncan's book is an interesting representation of some of these general trends in modern medical education. The book and its chapters are explicitly structured around reflection with regular 'question boxes' prompting the reader to examine their own thoughts, feelings and (potential) practices. There is a chapter devoted to historical perspectives and, following two chapters on 'standard' perspectives on medical ethical thinking, one which takes in professional codes and how they might be understood to relate to the character or virtuous individual practitioners. The developments in medical education over the past 20 years have exposed the inadequacy of teaching medical ethics from a perspective of applied ethics which is necessarily basic.. Whilst philosophy has been central and essential to the development of modern professional, medical and healthcare ethics we have realised that treating medical students as if they were philosophy students is an error.

Initial responses to this realisation, in the UK at least, were along the lines of vertical and horizontal integration of ethics education, and a

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great deal has been learned by medical educators and medical ethicists from these experiences. However there is now a number of developing approaches to ethical and moral education in medical and healthcare which aim at further engagement. The as yet predominantly US phenomena of 'professionalism' is one such strand as is a turn to the medical humanities, particularly history, literature and drama, in undergraduate medical education. Duncan's book adopts a third approach of having a central focus on the place of values in healthcare. Talk of values is often amorphous and uncertain. The relative neglect of virtue theory and neo-Aristotelianism in medical ethics and medical education is testament to both this and to the medical profession's preference for philosophical ethical objectivity embodied in rules, principles or utilitarian calculations.

The impact of reflective education and practice has been to undermine medical certainty and to promote self awareness. In the sphere of medical ethics the medical profession is beginning to acknowledge that it necessarily has an evaluative aspect, like Bosk's analysis of non-directive genetic counselling, reflective education is giving lie to the fact of a morally neutral medical profession or healthcare practice. Thus the open acknowledgement of value, both personal and professional, is an opportunity for engagement within the medical profession, interprofessionally and, ultimately, with the wider society of which healthcare is a part. Duncan's book is a direct attempt at encouraging such engagement on the part of professionals in training, practicing professionals and the professions as institutions.

On the whole *Values, Ethics and Healthcare* successfully facilitates and prompts reflection in a number of relevant areas. It cannot, of course, circumvent the inherent uncertainty of what it might mean for a profession or a professional to adopt x,y or z as a central value for their practice. This latter point reveals perhaps the difficulty in making a textbook seemingly designed to prompt individual reflection. Values must be seen a social or cultural phenomena; an aspect of the medical field. Whilst some professionals reading this book may take their reflections to work and discuss with their thoughts with colleagues, for others the reflective activity prompted by the book may merely serve to reinforce their existing perspectives. This, of course, may not be a bad thing but it is a limitation for the individual reader. The book is very much structured around what should, ideally, be group or classroom based discussions or exercises in reflection. This indicates the use that some of the readership of *Sociology of Health and Illness* may find for this book which, strangely, is not openly promoted by the publisher. For those of us who take classes or convene courses on ethics for medical students, postgraduate students or under the rubric of continuing professional development, Values, Ethics and Healthcare offers some interesting examples which might be appropriated as readings or discussion points by those seeking to refine or develop their courses.

Reference

C. Bosk. All God's Mistakes: Genetic Counselling in a Paediatric Hospital. Chicago University Press. 1995 (New edition) First Published: 1980.Nathan EmmerichQueen's University BelfastJune 2010

Hunter, D.J., Marks, L., Smith, K.E. *The public health system in England*. Bristol: The Policy Press, 2010 vii + 192pp. £17.59 (pbk) ISBN 978 1 84742 462 4 £52.00 (hbk) ISBN 978 1 84742 463 1.

Starting off a new series on evidence for public health practice, this volume from David Hunter, Linda Marks and Katherine Smith is a well informed discussion of England's public health 'system' and a review of changes to that system since 1974, when many public health functions were transferred from local government to the National Health Service (NHS). They draw on the large number of existing histories of and commentaries on public health, and interviews (mostly by telephone) with 28 individuals from various locations in public health policy and practice. The introductory chapters have two roles. The first is to rehearse the challenges facing public health, including the balance between upstream and downstream approaches to illness prevention, political debate around how far government can or should shape the choices individuals make, and the legitimate extent of the role of medicine, as a profession, within public health. This rehearsal is a necessary prelude to later discussion, but inevitably adds little to

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textbook accounts of public health. The second role of the early chapters is to make a case for treating those myriad practices, people and organisations that shape the conditions of health as 'a system'. As Hunter and colleagues note, the case is not self evident. Arguably, the range of regional agencies, local government, NHS, non-governmental organisations and interest groups rarely behave as 'system', despite many years of partnership initiatives at various levels, with elements often acting in isolation rather than articulation. More significantly, delineating the boundaries of the public health system quickly becomes an exercise in circularity. The authors admit that all policy and practice influence health at some level, yet to take the entire social, economic and political system as 'the public health system' would be unworkable. Their solution is to include only those agencies 'formally charged' with public health policy or implementation and those groups 'engaged in lobbying and campaigning in respect to various public health causes' (p.3). In line with contemporary moves towards taking policy complexity seriously, they claim the advantage of a 'systems' approach is the ability to think holistically and abstractly about messy and uncertain policy problem.

A well documented part of the messiness of public health lies in the tensions between NHS and local government, given that the NHS might have gained primary responsibility for public health in 1974, but local authorities control many major determinants of public health: social housing, transport systems, waste disposal. For Hunter et al, the root of resulting problems is that local government's engagement with public health has been problematic (p,137). Herein lies perhaps the weakness of an analysis that starts with a rather top down notion of a delineated 'public health system', and then questions the non-inclusion of any institutions not within it. If we were to ask instead questions about which parts of 'the wider system' had most impact on health, or on health inequalities, we might find it was road transport engineers, or the water board. Their engagement, or otherwise, with a self-conscious public health project seems redundant in any real consideration of whether 'public health' is being effectively enacted or not.

Two chapters of the book take a loosely historical perspective on the changes after 1974, and again after 1997, with the election of the Labour government. It is perhaps too early to assess New Labour's record on public health or health inequalities, and the commentary here shies away from so doing, except to conclude that long-standing concerns around the public health function, and the capacity of its workforce to discharge that function, remain. The breathlessness of the prose in the chapter on the years 1997–2009 reflects the rapid-fire policy initiatives of the era, with its endless succession of White Papers, organisational reforms and public health reports and enquiries. Up close, as the authors and their interviewees are, it is difficult to see coherence in the chaotic New Labour approach to the public health, with the contradictions in underlying models of public health implicit in various policy documents, and the push and pull of command and control evident in NHS reforms sitting uneasily with the language of devolution and partnership. Again, though, this apparent messiness may represent limits to a systems approach that reifies the 'public health system' and then asks what effects policies had on it. Other commentators have had more success in unpicking the underlying logics of New Labour modernisations, and starting with those, rather than with the public health system, may have shed more analytic light on the final questions of the book, on the contemporary challenges of globalisation, climate change and inequalities.

This is a useful text in that it does, in one handy reference, document policies that affected the public health workforce between 1974 and 2009, and the authors draw on a range of documents and briefings that did feed into Department of Health policy. However, the benefits of this feeling of reading an 'insider' account are offset by the cost of a certain parochialism – not in terms of geographical focus on England, but in terms of a critical stance. Little sociological theory or empirical research on public health is cited, and the broader cultural critiques that might have allowed a more genuinely abstract analysis are ignored. This does rather raise the question about who the book is for. Anyone working in public health in England will be familiar already with the issues documented here, and it is difficult to see why anyone not working in public health would be particularly interested. Sociologists may find the lack of any sociological analysis of the problems frustrating, and policy analysts may balk at the occasional rather taken-for-granted

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accounts of policy drivers. Both potential audiences may be disappointed with the lack of critical engagement. Debates and conflicts in research and theory are largely ignored, and there are no real attempts to critique the sources used, with empirical research, commentary and interviewee accounts are all treated over-respectfully as unproblematic accounts of 'what happened'. A more robust contribution to the debate about public health might have cost the authors their stance of disinterested appraisal, but might have broadened the appeal beyond academics in public health.

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