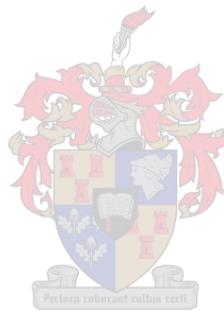


**Closing the Gap: Exploring Edentulism through Norman Daniels' Approach to Health  
and Healthcare**

by

Terence Albert Valentine

Thesis presented in partial fulfilment of the requirements for the degree of Master of  
Philosophy (Applied Ethics) at the University of Stellenbosch



Supervisor:  
Dr Susan Hall  
Faculty of Arts

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### **Declaration**

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## **Abstract**

### **Closing the Gap: Exploring edentulism through Norman Daniels' Approach to Health and Healthcare**

Statistics from the Western Cape Department of Oral and Dental Health Services show an alarming decrease in the construction of dentures by dentists working at state health facilities. In addition, statistical evidence shows that the most common treatment modality used by dentists in the public sector is extraction, the result of which is a growing sector of society presenting with partial or full edentulism. Edentulism is a condition characterised by partial or complete loss of natural teeth.

The aim of this thesis is to explore edentulism as a healthcare need in the light of Norman Daniels' approach to health and just healthcare provision. Daniels argues that healthcare is morally important because of the role that it plays in ensuring fair equality of opportunity. This thesis will argue that for individuals whose dependence is solely on the public healthcare system, edentulism can restrict opportunity. A requirement of justice would therefore require that denture or other appropriate prosthesis construction be incorporated into macro level healthcare design so that it would serve to protect and maintain opportunity in order for individuals to realise their life plans relative to others in their society. Where resource constraints make this difficult, Daniels' "Accountability for Reasonableness" approach can be applied to ensure that procedural justice is maintained in making fair decisions around rationing.

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## **Opsomming**

### **Vermindering van die Gaping: ‘n Ondersoek van tandeloosheid deur Norman Daniels se benadering tot Gesondheid en Gesondheidsorg**

Statistieke van die Weskaapse Departement van Mond en Tandheelkundige Dienste toon ‘n kommerwekkende afname in die konstruksie van kunsgebite deur tandartse verbonde aan die staat se gesondheidsfasiliteite. Daar is verdere bewyse wat aandui dat die mees algemene behandeling deur tandartse verbonde aan die openbare sektor die trek van tande is. Die laasgenoemde tandheelkundige behandeling veroorsaak ‘n groeiende sektor in die gemeenskap wat tandeloos is. Tandeloosheid is ‘n toestand gekenmerk deur gedeeltelike of algehele verlies van natuurlike tande.

Die doel van hierdie tesis is om tandeloosheid te ondersoek deur middel van Norman Daniels se benadering tot gesondheid en regverdige gesondheidsorg voorsiening. Daniels beweer dat gesondheidsorg van morele belangrikheid is vanweë die rol wat dit in die versekering van billike gelykheid van geleenthede speel. Hierdie tesis argumenteer dat persone met tandeloosheid en wat uitsluitlik van die openbare gesondheidstelsel gebruik kan maak ‘n beperking van geleenthede sal hê. Die vereiste vir regverdigheid sal dan op makrovlak by die beplanning van gesondheidsdienste aandag moet geniet oor die beskikbaarheid van fasiliteite vir die rekonstruksie van die gebit asook die beskikbaarheid van die aangewese prostese. Dit sal dan aan die beskerming van geleenthede voorsien ten einde die lewens beplanning van individue met tandeloosheid relatief tot ander in hul gemeenskap. In gevalle van beperkinge op hulpbronne kan Daniels se “Aanspreeklikheid vir Redelikheid” benadering toegepas word sodat regverdigheid gehandhaaf kan word in besluite rondom billike rantsoenering.

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### **Acknowledgements**

To my wife, Cheryl, and girls, Catherine and Samantha, thank you for your continued love, support and patience in bringing this thesis to a point of completion.

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## Chapter 1

### Introduction

A key aspect to achieving in life is being granted the opportunity to partake. To the reserve player being granted the opportunity to partake in the last minute of a world series would mean a dream come true. To the father of a family staring down the cold face of poverty, being called in for a work opportunity means that prayers have been answered. We need opportunity in order to realise our dreams and aspirations. Opportunity can however be stalled by eventualities that are out of our control. Misfortune could mean lost dreams and aspirations or it could serve as a trigger for us to alter our life plans to ones that we will be able to achieve.

In the following thesis, I will be looking at edentulism as a condition that could place infringements on opportunity, reducing the scope of life plans available to an individual. Edentulism is a condition characterised by partial or complete loss of natural teeth<sup>1</sup>. Data from the Western Cape Department of Oral and Dental Health Services reveals that extraction is the main treatment modality rendered to South Africans dependent on the public sector for their oral and dental needs<sup>2</sup>. The use of the treatment modality of extraction is subsequently contributing to edentulism within this sector. In addition, the data also revealed a cessation in the construction of dentures or other appropriate prostheses in the management of edentulism, thereby contributing to its growing prevalence. Edentulism, however, gives rise to extensive physiological and psychosocial effects. These detrimental effects are debilitating in respect of normal species-typical function. The result of this is a moral problem in that tooth loss, without the prospect of denture or other appropriate form of prosthesis construction, leaves a component of our community needing to cope with physiological and psychosocial challenges, often worsened by society's imposition of discriminatory penalties.

Questions can be posed in respect of the resultant moral dilemma. These questions include: How should we respond to the growing prevalence of edentulism? What are our moral obligations in terms of healthcare provision in this context, and how can we make sense of these moral obligations in the light of resource constraints? These questions will be

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<sup>1</sup> Please note that the content of discussion in this thesis does not reference or focus on partial edentulism resulting from voluntary front tooth extraction, which is outside the scope of this study.

<sup>2</sup> Statistics obtained from the Western Cape Department of Oral and Dental Health Services do not include statistics from Academic Institutions, but only from Primary Health Facilities.

approached through the application of Norman Daniels' approach to justice in healthcare in that it forms an ideal platform in dealing with intricacies associated with the management of edentulism. The central points of his theory are as follows. Firstly, healthcare is morally important because it contributes towards fair equality of opportunity. Secondly, causation exists between the delivery of Rawls' societal goods and the measure of health within a given society. Finally, where decisions around rationing are to be made, procedural justice and public accountability must be ensured. These central points will be discussed in greater detail in respect of their relevance to the management of edentulism in the proceeding chapters.

The discussion in this thesis will proceed as follows. In Chapter 2, I will discuss aspects pertaining to the physiological and psychosocial effects of edentulism and their relation to the World Health Organisation's (WHO) classifications of impairment, disability, and handicap. I will also discuss the manner in which the public health sector renders service to communities, with specific attention to the manner in which edentulism is managed by the Western Cape Department of Oral and Dental Health Services.

In Chapter 3, I will focus on the key features of utilitarian and deontological moral approaches as contributors to the South African healthcare system. I will also elaborate on the shortfalls of these theories in dealing with challenges pertaining to the management of edentulism. Chapter 3 also sees the introduction of Daniels' approach to health and healthcare. In my discussion, I present Daniels' approach as an ideal supplement to traditional moral theories, in that it is able to address some of the challenges within healthcare provision which are related to the shortfalls inherent in utilitarian and deontological moral approaches.

In Chapter 4, I present Daniels' theory of just healthcare in more detail. This chapter is divided into three sections. The first section explores the development of Daniels' approach to health and healthcare in order to give clarity on the moral importance of healthcare. The second section discusses the distribution of Rawls' primary goods as a determinant of health. The third section explores the topic of limit setting for healthcare, and considers how we can ensure that provision remains fair when a lack of resources makes it impossible to provide for each health need.

In Chapter 5, I evaluate the Western Cape Department of Oral and Dental Health Services' approach to edentulism and the construction of dentures and other appropriate prostheses in the light of Daniels' theory. The discussion follows the three part format as detailed in

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Chapter 4. In the first section I present edentulism as a health need that requires management in order to restore species-typical function so as to protect and maintain opportunity. In the second section I discuss the inequitable distribution of primary goods as a determinant of health with specific reference to Coloured farm-workers as an illustrative example. In the third section I present Daniels' "Accountability for Reasonableness" approach as a means to ensure procedural justice when decisions need to be made around edentulism in respect of limited resources.

In Chapter 6, I present concluding remarks in respect of Daniels' approach to health and healthcare relative to the management of edentulism and the construction of dentures or other appropriate prostheses by the public health sector.

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## Chapter 2

### An Empirical Review

#### 1. Introduction

The aim of this chapter is firstly to elaborate on the physiological and psychosocial effects of edentulism. Further discussion investigates the manner in which the Western Cape Department of Oral and Dental Health Services renders service to communities whose total dependence is on public health services and in particular, how edentulism is managed by the Western Cape Department of Oral and Dental Health Services.

To introduce this chapter, we can consider the following statement from Deborah L. Rhode (2009: 1035): “appearance imposes penalties that far exceed what most of us assume or would consider defensible”. In March 2013, a local newspaper printed a story that depicted the depth of Rhode’s statement (Cape Town Nurse Sent Home for No Front Teeth, 2013). A healthcare worker, employed at one of Cape Town’s private hospitals, misplaced her denture prior to reporting for duty. On arrival at her station, she was summarily asked to leave and only to return upon having had a new denture constructed. Rhode (2009: 1035) argues that such practices, based upon appearance, are discriminatory and is of the opinion that this is an injustice that requires legal remedy. One is led to ask whether edentulism, a condition characterised by either full or partial loss of natural teeth, could give rise to appearances so disconcerting that it could validate society’s imposition of such severe penalties. In the following discussion, I aim to elaborate on the physiological and psychosocial effects of tooth loss in order to determine whether edentulism could be contributory to such disconcerting appearances and ultimately society’s imposition of penalties. Secondly, I aim to investigate the impact of treatment offered by the Western Cape Department of Oral and Dental Health Services in the management of edentulism.

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## **2. Physiological and Psychosocial Effects of Tooth Loss.**

### **2.1 Physiological Effects**

In my discussion, I shall be reviewing the physiological impact of tooth loss both intra and extra orally. An overview of the key functions of teeth reveals the following aspects:

- Effective chewing is a process that initiates the complex process of digestion. Teeth serve a central function in chewing in that they are the prime contributors to the mechanical breakdown of foods into smaller particles. Subsequent chewing furthers the process of digestion in that the small food particles are dissolved in saliva. Through this process the finer food particles are maximally exposed to salivary enzymes. These salivary enzymes initiate the chemical breakdown of complex carbohydrate molecules.
- Teeth also serve an important function in the production of clear speech. The production of clear speech requires that the tongue be positioned in precise locations within the oral cavity in order to generate audible and clear sounds. Ritchie and Ariffin (1982: 26) conclude that in order to restore proper sound production in edentate patients, the correct palatal contour and positioning of anterior teeth in newly constructed dentures is an important requirement.
- Teeth serve another important function in that they contribute to the maintenance of bone integrity within the jaws. Mechanical stimulation of the alveolar bone occurs as a result of forces generated through chewing and occlusion, being transmitted along the root lengths (Bodic, Hamel, Lerouxel, Basle & Chappard, 2005: 215). This process serves a stimulatory function in that it maintains the health of the alveolar bone housing the teeth. Loss of teeth results in bone previously stimulated, undergoing resorption. This process contributes to changes that are most notable both intra and extra orally.

Having discussed the key functions of teeth, we can now move on to consider the impact of tooth loss.

#### **2.1.1 Intra Oral Effects**

The portion of bone in the jaws that houses teeth is called the alveolar bone. Teeth function to maintain the density, strength and form of the alveolar bone through the transmission of forces along the root lengths. The consistency of force transmission along the root lengths has a stimulatory effect ensuring that the alveolar bone remains dense and in a state of good health. It can therefore be deduced that the loss of teeth results in a reduction of force

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transmission with a resultant loss of alveolar bone due to reduced bone density both locally due to partial tooth loss and generally as a result of total tooth loss.

Bone loss varies considerably between the upper and lower jaws in edentulous patients. Tallgren (quoted in Adam, Geerts & Lalloo 2006: 10) demonstrates that the loss of bone in the lower jaw is four times greater than that in the upper jaw. Such extensive bone loss in the lower jaw would present as a loss in both the width and height of the residual ridges. The result of this is increased denture instability and often an inability to wear dentures due to a reduced denture bearing area. Deeper lying anatomical structures such as the mylohyoid ridge and genial tubercles become more prominent. Forces applied by dentures onto fragile mucosal membranes covering these bony prominences contribute to difficulty in the wearing of dentures. This occurs as the fragile mucosal membranes ulcerate due to continued exposure to pressure.

Extensive alveolar bone loss contributes further to denture instability as a result of the Inferior Alveolar nerve becoming exposed. This nerve, normally covered by bone, now lies directly under the mucosal membranes of the reduced denture bearing area. Pressure applied by lower dentures onto the exposed nerve results in temporary or permanent loss of sensation to areas innervated by it.

According to Budtz-Jorgensen (1981: 65), flabby ridges result from the replacement of alveolar bone by fibrous tissue in both upper and lower jaws. According to Coelho, Sousa & Dare (2004: 138-139), flabby ridges are often the result of the length that a denture is worn resulting in the old ill-fitting denture causing trauma and inflammation of the supporting tissues. The subsequent change within the ridges further contributes to the instability of dentures.

### **2.1.2 Extra Oral Effects**

Tooth loss with subsequent alveolar bone loss has a dramatic effect on the facial appearance of an individual. This is particularly characteristic of patients who are completely edentulous. A characteristic feature of complete edentulism is the loss of lower anterior facial height. According to Al-Zubaidi and Obaidi, the “lower anterior facial height can be defined as the vertical distance between the anterior nasal spine and the menton points” (2006: 106). In other words, the lower anterior facial height is a measurable distance between the nostril area and the tip of the chin. The measurable loss of lower anterior facial

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height contributes greatly to an accelerated aged appearance as the lower jaw undergoes an upward and forward rotation. The resultant effect of this is a pronounced prominence of the chin with deepening angular lines at the corners of the lips. These individuals have an unhappy appearance when their mouths are in a postural position of rest.

### **2.1.3 Physiological Effects in Summary**

It is clear from the foregoing discussion that edentulism impacts extensively both intra and extra orally. Central to the effects described both intra and extra orally is bone loss, the result of complete dental clearance (complete loss of all natural teeth) in both jaws. The loss of bone gives rise to exposure of deeper lying anatomical structures such as the mylohyoid ridge, genial tubercles and neurovascular bundles in the lower jaw; as well as to fibrous change within ridges causing them to become flabby. These changes reduce denture bearing areas with a resultant loss of denture stability.

The extra oral effect of edentulism has a marked effect on facial appearance. Extensive bone loss may induce an accelerated aged appearance in edentate individuals due to a loss of anterior vertical facial dimension. Impacts such as these physiological changes contribute to the psychosocial effects discussed in the next section.

## **2.2 Psychosocial Effects**

### **2.2.1 Tooth Loss as Impairment, Disability and Handicap**

The World Health Organisation (WHO) provides a classification for impairment, disability and handicap. According to this classification, impairment is classified as “any loss or abnormality ... of an anatomic structure” (WHO, 1980: 4). Disability is classified as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (WHO, 1980: 143). The WHO (1980: 143) characterises these “deficiencies of customarily expected activity, performance and behaviour” as “temporary or permanent, reversible or irreversible, and progressive or regressive.” Handicap is classified as “a disadvantage for a given individual resulting from impairment or a disability that limits or prevents the fulfilment of roles that is normal (depending on age, sex, and social and cultural factors for that individual)” (WHO, 1980: 183). The specific emphasis here in respect of being handicapped is the disadvantage to the individual relative to peers when viewed from the norms of society (WHO, 1980: 183).

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Adam et al (2006: 14) present the WHO classification as a basis for the assertion that “the loss of all natural teeth may lead to impairment, disability and handicap.” The loss of teeth can be seen as impairment in that it is representative of a loss of an anatomic structure. Tooth loss can be determined as a disability in that activities such as chewing cannot be performed within a range considered normal when compared to dentate individuals. The loss of teeth can also present itself as a handicap, particularly where a denture or other appropriate prosthetic device is not provided, in that an individual affected by it may have limited access to job opportunities, for example, in applying for a job in an up-market retail store relative to a dentate counterpart. The edentate individual is more likely assured failure in such an application.

Substantiating the claim of Adam et al (2006: 14) is work done by Fiske, Davis, Frances, and Gelbier (1998: 90) and Davis, Fiske, Scott, and Radford (2000: 503) in which they looked at the emotional effects of tooth loss. Fiske et al (1998: 90) identified the following themes through a qualitative study in which 50 edentulous people were interviewed: bereavement, lowered self-confidence, altered self-image, dislike of appearance, an inability to discuss this taboo subject, a concern about prosthodontic privacy, behaving in a way that keeps the tooth loss secret, altered behaviour in socialising and forming close relationships, and premature ageing. They concluded in light of their findings that the impact of tooth loss can have a profound impact on the lives of some people, even those who are coping well with dentures.

Davis et al (2000: 503) determined that forty five percent of his research population experienced the following themes following the loss of their teeth: being “more likely to feel less confident about themselves; more likely to feel inhibited in carrying out everyday activities; and less able to accept the inevitable change in facial shape which occurs following the loss of teeth.” They also determined that over three-quarters of the people who felt unprepared following the loss of their teeth felt that an explanation from the dentist would have assisted in helping them process the change. They concluded that the effect that tooth loss can have on the lives of people should not be underestimated.

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### **2.2.2 Psychosocial Effects in Summary**

Common themes identified from the aforementioned research into the effects of tooth loss included lowered self-confidence, altered self-image, altered behaviour in socialising and forming close relationships, and being more likely to feel inhibited in carrying out everyday activities. These themes underline the validity of Adam et al's (2006: 14) assertion that tooth loss can lead to impairment, disability and handicap, in the sense that these terms are defined by the WHO.

### **3. Edentulism in the Western Cape**

This section investigates the impact of treatment offered by the Western Cape Department of Oral and Dental Health Services upon the management of edentulism. Special note should be made of the fact that within South Africa only 18% of the population have access to private healthcare while the remaining 82% of the population are dependent upon the public sector (Healthcare in South Africa, 2014). In February 2014, I received procedural data from the Western Cape Department of Oral and Dental Health Services. This data was collated from oral health centres across the Western Cape. The compiled data is used to determine the efficacy with which services are rendered to local communities. The services include various procedures of which the restoration of teeth, extractions, and the construction of dentures form part of a greater tally. Patients are categorised by their point of contact with an oral healthcare service provider. Four points of contact have been identified. The first patient type is called 'school' as patients from this group were identified for treatment through school programmes. This group is generally aged between five and eighteen. The second patient type is called 'department' as these patients are those who would attend oral health centres out of a need to have a dental concern attended to. The age of these patients could vary as they could include children brought directly to oral health centres by their parents. This group however contains a large percentage of adults for whom the oral health centres are the only contact point for dental treatment. The third patient type is called 'prison'. These patients, primarily adult, are seen through oral health programmes run in prisons across the Western Cape. The fourth patient type is constituted out of a specific group of children aged under five.

As my interest is directed to the adult denture wearing population within our communities, I had to identify a patient type that would constitute patients of adult age. The emphasis on patients of adult age is central to the development of my argument. Patients of the

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‘department’ type attending oral health centres could not be included in my analysis as the data collection process does not distinguish between adult and children attendances. The patient type designated ‘prison’ offered a more acceptable range of patients for analysis. The age range of patients within the prison population ranges from teenagers through to the elderly. The presence of teenagers within this group does not disqualify its use. In respect of tooth eruption ages, teenagers would already have a fully functional adult dental complement. Through the use of dentition as a determinant, teenagers would therefore qualify as part of the adult group in the analysis. The use of the prison type patient base fulfilled my requirements for two reasons. Firstly, it constituted an adult base; and secondly, oral healthcare services available to other patient types were performed with the same treatment rationale.

Statistical data received from the Western Cape Department of Oral and Dental Health Services revealed interesting findings pertaining to attendance versus restoration (or filling) of teeth, attendance versus extractions performed, and the construction of dentures, for the period 2004 through to 2011 (see Table I).

<b>Table 1.</b>		
<b>An Analysis of Dental Attendances within the S.A. Prison Services, Western Cape.</b>		
<b>Period 2004 - 2011</b>		
Statistics for the Western Cape Department of Oral and Dental Health Services		
<b>Attendances</b>		<b>59 402</b>
<b>Extractions</b>		<b>95 336</b>
<b>Restorations</b>		<b>655</b>
Amalgam	89	
Composites	566	
<b>Dentures</b>		<b>140</b>
Full	71	
Partial	69	

The data reveals that for the period, 59 402 attendances were noted. It should be noted that this figure indicates attendances rather than individual patients. The significance of this is that a single patient could have been registered for multiple attendances in order to complete

his or her treatment. A point of interest is the number of extractions performed i.e. 95 336, relative to the attendances registered. A calculation of extraction against attendances reveals that 1.60 teeth were extracted per attendance. Teeth restored (or filled) for this period totalled 655 of which 89 were amalgam (metal based) restorations and 566 composite (tooth coloured) restorations. Calculations of restorations against attendances reveal that only 0.01 restorations were performed per attendance. In comparing 1.60 extractions per attendance with 0.01 restorations per attendance, it is evident that extraction is the main treatment modality used by oral health workers employed by the Western Cape Department of Oral and Dental Health Services. The resultant of such extensive extraction statistics is a high degree of edentulism. Edentulism, as previously mentioned, is a condition characterised by either full or partial loss of natural teeth. The construction of 140 dentures over an eight year period, of which 71 were full and 69 partial, indicates that management of subsequent edentulism created through extensive extraction is not a priority given sufficient attention.

<b>Table 2.</b>		
<b>An Analysis of Denture Construction within the S.A. Prison Services, Western Cape.</b>		
<b>Period 2004 - 2011</b>		
Statistics for the Western Cape Department of Oral and Dental Health Services		
<b>Year</b>	<b>Full Dentures</b>	<b>Partial Dentures</b>
2004	14	7
2005	6	9
2006	8	13
2007	24	19
2008	10	17
2009	0	4
2010	6	0
2011	0	0
<b>Subtotal</b>	<b>71</b>	<b>69</b>
<b>Grand Total</b>	<b>140</b>	

Table II represents statistical data showing the number of dentures, both full and partial, constructed by the Western Cape Department of Oral and Dental Health Services for the period 2004 to 2011. Of specific note is the observation that following a dramatic spike in denture construction in 2007, denture construction ground to a complete halt in 2011. The complete halt in denture construction is evidence that edentulism is not given priority by management. From the statistics it is therefore evident that extraction constitutes the most favourable treatment modality while the construction of dentures to close the resultant gaps in a patient's bite is rarely, if ever, undertaken among the prison population.

#### **4. Conclusion**

An elaboration of the effects of tooth loss has shown that it is at the centre of extensive physiological and psychosocial changes. Most notable of the physiological changes is the reduction of the denture bearing area intra orally and the onset of premature ageing extra orally. These physiological changes have a negative effect on the psychosocial condition of individuals within communities. In research done by Davis et al (2000: 503), they concluded that the effect of tooth loss on people and the subsequent manner in which they live their lives should not be underestimated. Adam et al (2006: 14) draws on these extensive physiological and psychosocial effects when putting forward the assertion that "the loss of all natural teeth may lead to impairment, disability and handicap." The physiological and psychosocial effects of edentulism could give rise to discrimination based on appearance with immense impact on career performance according to Rhode (2009: 1035). This is particularly evident in modern day society where beauty in the form of appearance and confidence in function is of utmost importance.

Statistical data obtained from the Western Cape Department of Oral and Dental Health Services revealed disconcerting results. Their statistics revealed that extraction was the most commonly used treatment modality in the prison services and that the management of edentulism through the construction of a denture or other appropriate prosthesis was given very low priority. Given that this is likely to be at least representative of dental services in the public health sector for the province as a whole, it does not bode well for the eighty two percent of South Africans dependent on public health facilities. Although the construction of dentures does not entirely prevent physiological and psychosocial changes, it reduces their impact while ensuring good aesthetics and function. Due to the costly nature of various

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forms of prostheses, the emphasis in this thesis is on the delivery of acrylic or plastic dentures by the Western Cape Department of Oral and Dental Health Services.

The Western Cape Department of Oral and Dental Health Services' use of extraction as the default treatment modality, and the failure to provide dentures or other appropriate prostheses, gives rise to a moral problem. This moral problem arises from the fact that tooth loss, without the prospect of denture or other appropriate form of prosthesis construction, leaves a large component of our community needing to cope with physiological and psychosocial challenges often worsened by society's imposition of discriminatory penalties.

In the proceeding chapter, I present an analysis of this moral problem in the light of relevant moral theories. I begin by investigating the impact of moral theories on the development of theoretical frameworks that influence decision-making around public health interventions.

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## Chapter 3

### Moral Theories and Approaches that Impact upon South African Healthcare in the Public Sector

#### 1. Introduction

In the preceding chapter, I discussed both the physiological and the psychosocial effects of edentulism. My discussion also investigated the manner in which the Western Cape Department of Oral and Dental Health Services renders services to communities totally dependent on the public sector as represented by dental services offered to the prison population. This investigation revealed a moral problem. This moral problem is based on the determination that tooth loss without the prospect of denture or other appropriate form of prosthesis construction leaves a large component of our community needing to cope with physiological and psychosocial challenges often worsened by society's imposition of discriminatory penalties. The moral problem identified requires analysis through a suitable moral theory. The aim of this chapter is to investigate the contribution of moral theories to healthcare policy with specific emphasis on the strengths and weaknesses of these theories.

The South African healthcare system, like healthcare policy internationally, is influenced by various moral theories and approaches. These moral systems mould healthcare in that they form the foundations from which arguments are developed that validate decisions relating to the formulation of healthcare policies in both the private and public sectors. As these moral systems form the background to the development of my argument, I aim to explore them in greater detail with respect to their key features.

According to Van Niekerk (2013: 20), Utilitarian and Kantian Deontological moral reasoning are closely “associated with the advent of the modern world”, “and, more particularly, the Enlightenment in Western Europe”. Van Niekerk (2013: 20) continues by stating that they “are by far the best-known approaches to moral reasoning in current day ethics literature.” These theories have however been unable to provide the tools for thinking through and justifying solutions to moral problems surfacing in modern biomedicine. H.L.A. Hart (quoted in Beauchamp & Childress 2009: 351) presents the example of liberal individualism challenging the reigning Utilitarian and Kantian Deontological moral theories as a challenge between an old and a new faith. Biomedical ethics has subsequently become littered by

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theories aimed at adding new conceptual understanding to the framework of the classic theories.

In the following discussion, I aim to elaborate on the key features of Utilitarian and Deontological theories as well as elaborating on the shortfalls of these approaches in dealing with challenges pertaining to the development of my argument. My discussion also introduces Norman Daniels' approach to health and healthcare as a useful supplement for making decisions about the kind of health interventions that a healthcare system is required to provide. Daniels' perspectives have the potential to meet the underlying challenges of my argument, ensuring a more thorough elaboration of what healthcare ought to provide, relative to the shortfalls inherent in approaches such as Utilitarian and Kantian Deontological moral theories.

Through the proceeding discussion I aim to firstly fulfil my goal of acquiring a foundational understanding of the impact of classic moral theories on the formulation of healthcare in South Africa, and secondly, to establish Daniels' approach to health and healthcare as the key approach to be used in the development of my argument.

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## 2. Utilitarianism

### 2.1. Utilitarianism in Brief

Consequentialism, of which utilitarianism is a form, is an approach in which the “right act in any circumstance is the act that produces the best overall result as determined by the relevant theory of value” (Beauchamp & Childress, 2009: 337). Jeremy Bentham (1748-1832) and John Stuart Mill (1806-1873), generally regarded as the fathers of utilitarian theory, promoted the hedonistic value of well-being which may be perceived in terms of happiness and welfare. Their utilitarian moral theory is based on one principle, namely the principle of utility. This principle is described as the need to always “produce the maximal amount of positive value over disvalue (or the least possible disvalue, if only undesirable results can be achieved)” (Beauchamp & Childress, 2009: 337). Mill (1901: 9-10) summarises utilitarian moral theory in the following manner:

The creed which accepts as the foundation of morals, Utility, or The Greatest Happiness Principle, holds that actions are right in proportion, as they tend to produce happiness, wrong as they tend to produce the reverse of happiness. By happiness, is intended pleasure and the absence of pain, by unhappiness pain and the privation of pleasure.

Rachels and Rachels (2010: 109) present a concise summary of key features of classical utilitarianism in the following three propositions:

- (a) Actions are to be judged right or wrong solely by virtue of their consequences; nothing else matters.
- (b) In assessing consequences, the only thing that matters is the amount of happiness or unhappiness that is created; everything else is irrelevant.
- (c) Each person’s happiness counts the same. Thus, right actions are those that produce the greatest balance of happiness over unhappiness, with each person’s happiness counted equally important.

In more recent times, utilitarian philosophers have argued that values other than happiness contribute to well-being. In one such version of utilitarianism, the principle of utility references the maximised “satisfaction of the preferences of the greatest number of individuals” (Beauchamp & Childress, 2009: 337). Sutcliffe Burrows (2013) presents Preference Utilitarianism, originally developed by R.M. Hare and Peter Singer, as a modern version of utilitarianism. The key difference between this version and classic utilitarianism is

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that the satisfaction of a person's preferences is what matters, rather than the greater balance of pleasure over pain (Sutcliffe Burrows 2013). Sutcliffe Burrows (2013) gives the example of the marathon runner whose preference it is to subject him or herself to the agony of running for a charity in order to obtain satisfaction.

There are two versions of classic utilitarianism, namely act utilitarianism and rule utilitarianism. Act utilitarianism suggests that the character of actions such as lying or torture, generally regarded as abhorrent, would be irrelevant in so far as the actions maximise utility. Rule utilitarianism, however, determines that the morality of an action is determined in accordance with which rules, when accepted by the majority, would have the best consequence and is therefore more in line with conventional morality. Act utilitarians often criticise rule utilitarians in that when actions contrary to conventional morality are required, rule worship becomes problematic (McMillan, 2013: 6).

Various philosophical objections have been raised against act utilitarianism in its application. One such objection was raised by a well recognised nineteenth century physician and rule utilitarian with regard to truth telling in medicine. Worthington Hooker (quoted in Beauchamp & Childress, 2009: 340) stated the following:

The good, which may be done by deception in a few cases, is almost as nothing, compared with the evil which it does in many, when the prospect of its doing good was just as promising as it was in those in which it succeeded. And when we add to this the evil which would result from a general adoption of a system of deception, the importance of a strict adherence to the truth in our intercourse with the sick, even on the ground of expediency, becomes incalculably great.

Hooker argues here that ongoing deception in the practise of medicine will result in greater harm than good over time. The maintenance of rules is essential to the rule utilitarian as it ensures the integrity of the specific rule, in this case truth-telling, as well as the integrity of the entire system of rules (Richardt B. Brandt quoted in Beauchamp & Childress 2009: 340). Beauchamp and Childress (2009: 340) presents the act utilitarian's defence as one in which the importance of rules such as promises should be kept in order to maintain trust. However, if their maintenance prevents the maximising of the overall good, they should be put aside. Rules according to act utilitarians should rather be seen as guidelines for living rather than non-negotiables.

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In the following discussion, I consider the application of utilitarianism in the formulation of healthcare policy.

## **2.2. Utilitarianism and Healthcare Policy**

Morality, according to utilitarian principles, is essentially consequentialist based. In a utilitarian healthcare system this would imply that healthcare outcomes should promote the welfare of the greatest number. Actions should at their core submit to the obligation of beneficence in order to promote welfare and the obligation of non-maleficence to minimise harm.

The utilitarian obligation to promote welfare makes it well suited to the development of public health policy particularly in instances where scarce resources need distribution. Garbutt and Davies (2011: 269) describe utilitarianism as the efficient administrator of medical systems. Their discussion of utilitarianism in respect of the UK NHS reflects the need to get the most out of a limited healthcare budget. Utilitarians achieve this through the introduction of protocols aimed at ensuring good choices through constraint, thereby promoting clinical efficiency and cost effectiveness. Although the introduction of such protocols is not looked upon favourably by many clinicians, administratively it presents as a reasonable option. The utilitarian nature of this is explained by Beauchamp and Childress (2009: 343) as that which maximises good outcomes for all affected in respect of an objective assessment of everyone's interests.

An example of the application of utilitarian reasoning to healthcare policy is the notion of QALYs, or Quality Adjusted Life Years. QALYs are a type of Health Adjusted Life Year (HALY) which, according to Beauchamp and Childress (2009: 231), are measures "that combine longevity with health status". Beauchamp and Childress (2009: 231) explain that the origins of the use of QALYs in developing healthcare policy lie in the understanding that many patients receiving chronic or rehabilitative care would "trade some life-years for improved quality of life during their remaining life-years". QALYs compare different interventions with regard to their impact upon overall welfare. A key feature of QALYs is that they can potentially assist in determining the justifiability of costs relative to the effectiveness of different treatments (Beauchamp & Childress, 2009: 231).

McMillan (2013:2) gives an example in which the cost per Quality Adjusted Life Year (QALY) for new radon gas remediation is compared to a pneumococcal vaccination for the elderly. According to this example, the outcome revealed that due to the lesser cost of the vaccine, more QALYs could be produced by choosing this treatment. Although radon gas

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remediation is beneficial to individuals as a treatment modality, its cost to benefit ratio reveals an unfavourable balance of benefits and costs to the greater society in comparison to other interventions (it delivers fewer QALYs). It could therefore be stated that in a limited healthcare budget where we must choose between treatment modalities, the utilitarian economic rationale favouring the maximisation of QALYs per monetary unit spent would be most favourable.

In the early days of HIV/ AIDS management within South Africa, the use of QALYs gave rise to extensive critique (Horn, 2003: 36). The use of QALYs was part of South African policy, justified on grounds of cost effectiveness. Horn (2003: 36) states that through the use of QALYs, the State thought it economically more viable to provide prophylaxis against opportunistic infections rather than providing anti-retrovirals to HIV positive patients in order to prevent the development of full blown AIDS. The emphasis of the critique centred on the justifiable provision of anti-retroviral treatment to all HIV positive patients on moral grounds (for example, respect of persons, obligations of rescue and beneficence, and so on) rather than the use of a utilitarian economic rationale (Horn, 2003: 36).

From the two case studies, we see that QALYs have been used as an analytical modality by utilitarian thinkers to quantify the cost effectiveness of healthcare policy decisions. A critique of this quantifying system is that it favours life-years over individual lives. The result of this, as depicted in the South African HIV/ AIDS scenario, is that lives that need urgent care are often ignored. This strongly presents the most common shortfall associated with the application of utilitarian protocols. A patient group whose treatment modality is not determined as cost effective therefore fails to receive treatment in light of the utilitarian economic motto, the greater good for the greater number.

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### 3 Kantian Deontology

#### 3.1. Kantian Deontology in Brief

The determination of morality in respect of utilitarianism and deontology differs significantly. Utilitarian morality as previously discussed, is determined by the degree to which the consequence of an action maximises utility within society. Deontology is nonconsequentialist in that each action has its own inherent moral worth. One cannot reason that because Robin Hood had stolen from the rich to give to the poor that his action could be determined morally right. Such reasoning would be consequentialist in that it would be deemed morally right to steal from a rich minority in order to give to the poor because it would maximise utility. To the deontologist stealing is morally wrong, regardless of the setting.

Clarke (2009: 55) introduces Immanuel Kant (1724-1804) as one of the most important philosophers of the enlightenment. Kant, the author of Kantian deontology, although a devout protestant, “was determined to set morality free of theology” as he “believed that moral law corresponded to human reasonableness” (Clarke, 2009: 55). Kant’s idea was to move away from the very influential cultural perspective that moral rules derive their authority from a divine being (Van Niekerk, 2013: 25).

He grounded morality on two basic capacities: our capacity to reason and our capacity for freedom. The moral character of our deeds flows from an inherent rational capacity that we have as human beings. This rationality forms the foundation from which we are able to tell right from wrong. The morality of our actions according to Kant is therefore not based on authoritative rules legislated from an outside theological source but from that which is within us.

Kant identifies our capacity for freedom as the basis for autonomy. Autonomy simply means our capacity to morally “legislate” for ourselves (Van Niekerk, 2013: 26). We have an independent will that allows us to determine our individual outcomes. Autonomy stemming from our capacity for freedom and rationality from our capacity to reason therefore forms the foundation to Kantian morality.

The application of rational autonomy in the determination of the moral worth of an individual’s action is dependent primarily on the acceptability of a predetermined rule on which an individual acts. This rule is synonymous with right motive according to Van

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Niekerk (2013: 26), who elaborates on this by saying that acting morally requires us to act on the right motive which in turn means doing the right thing for the right reason. Doing the right thing for the right reason introduces the concept of duty. This sense of duty governing our action is defined by Kant as a command that reason places on the human will. Kant formulates this command into what he calls “categorical imperatives” or unconditional demands (Van Niekerk, 2013: 26). Two versions of the categorical imperative were formulated by Kant (Van Niekerk, 2013: 26):

1. Act only on that maxim through which you can at the same time will that it should become a universal law, and
2. Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end.

The first formulation states that the maxim or rule that determines the morality of our actions is such that we should be able to adopt it as a universal law with consistency. The second formulation emphasises that our actions should recognise and therefore respect individual autonomy. Individuals should be recognised as ends in themselves and never as a means to another’s end. In certain circumstances, however, a person may be used as a means but only as a consenting person. In this scenario, consent in the performance of duty is of central importance. An example of this would be calling on a plumber to fix a leaking tap. In this case the plumber serves as a means to the landlord’s end of improved home maintenance. However, the plumber, in consenting to fix the leaking tap, adopts the landlord’s end as his own and is therefore not being used as a means only, but also as an end in himself.

### **3.2. Kantian Deontology and Healthcare Policy**

In contrast to utilitarianism being presented as the efficient administrator of healthcare, deontology is presented as the dutiful clinician (Garbutt & Davies, 2011: 268). Kant stipulates that actions performed out of virtue, emotion or sympathy are of no moral worth. He asserts that only actions that are performed out of duty have moral worth. Rachels and Rachels (2010: 128) present actions performed out of virtue, emotion or sympathy as being linked to hypothetical ‘oughts’. They differentiate between hypothetical ‘oughts’ and categorical ‘oughts’. Hypothetical ‘oughts’ are driven by our desires and therefore not binding while categorical ‘oughts’ are binding on our actions as we have reason to expedite them (Rachels & Rachels, 2010: 128). Clinicians are therefore bound to perform their duty

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towards their patients. Although it is expected of healthcare providers to deliver their responsibility towards their patients out of an obligation of duty, acting out of duty alone might seem to imply that a healthcare provider is morally deprived. Rachels and Rachels (2010: 168) discuss the case of Mr Smith who visits a patient in hospital primarily out of a sense of duty and not out of a sense of genuine empathy. Mr Smith reasons that visiting patients in a hospital is the right thing to do despite lacking a genuine sense of empathy for the patients visited. From this case it is evident that theories such as Kantianism which focus primarily on the right action, fails to provide a satisfactory account of moral life by referring only to the binding nature of the dictates of reason. Being invested with a motivation to function out of duty should also allow for space in one's moral wherewithal to accommodate for virtue, emotion or sympathy. Healthcare providers who can respond to their patients with empathy yet deliver a service with the utmost of obligation would seem to display superior moral worth to those who merely act out of duty.

Kant's categorical imperative states that we ought to always treat humanity never as a means, but always as an end (Van Niekerk, 2013: 26). Healthcare providers should therefore respect their patients as ends by respecting their autonomy. This would mean providing them with all relevant information and allowing them to make informed decisions about their own treatment. Contravention of this categorical imperative translates into a failure to recognise the autonomy of the individual. History is littered with various incidences where the main accusation was the failure to recognise the individual autonomy of a research participant or that of a patient being managed. The Tuskegee Syphilis study (1932-1972) conducted by the U.S. Public Health Service is one such example (U.S. Public Health Service Syphilis Study at Tuskegee, 2013). In this study 600 low-income African American males, 399 of whom were infected with syphilis, were monitored for 40 years. During this period the participants were not told of the condition, and when a proven cure became available in 1947, they were not provided with it. When individuals were diagnosed by healthcare practitioners outside of the study as having syphilis, researchers would intervene, preventing treatment. Many of the subjects died during the study. Participants in this study were used, many fatally so, as a means to the ends of the U.S. Public Health Service who acted in direct contravention of the individual autonomy of the research participants.

Deontology requires that patients be managed in accordance with duty and with respect for autonomy. In addition, it is also expected of healthcare providers that in being motivated by good moral reasoning to do the right thing, their actions should be characterised by

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consistency. The need for consistency stipulates that what is morally correct in one setting is morally correct in another. Consistency in morality is extracted from Kant's categorical imperative that stipulates that we ought to "act only on that maxim through which you can at the same time will that it should become a universal law" (Van Niekerk, 2013: 26). In healthcare this could however lead to conflict as occasions could arise when full disclosure is a necessity whereas in another situation partial disclosure could serve to protect a vulnerable individual.

Utilitarians often criticise Kantian deontology's application to healthcare in that the deontological healthcare practitioner is required to be everything to everyone. Although the utilitarian emphasis in healthcare seeks to provide welfare to the greater community, consistency cannot be guaranteed under this approach as harm to an individual is inevitable in a system where the greater good for the greater number is sought (Garbutt & Davies, 2011: 269). The utilitarian argument centres on the fact that the deontological healthcare practitioner possesses "finite capacities in terms of energy, concentration, resources and money to deal with everyone in his/her waiting room" (Garbutt & Davies, 2011: 269). The utilitarian perspective therefore asserts that there are too many patients requiring healthcare for providers to treat each patient as though they are the only ones in need of treatment. The call is therefore to provide and use resources effectively from the perspective of both the healthcare administrator and the healthcare provider.

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#### 4. Shortfalls of Classic Moral Theories

In the preceding sections of this chapter, the discussion had elaborated on the classic moral theories, namely utilitarianism and Kantian deontology. Within the scheme of public health, utilitarianism proves itself as the efficient administrator of medical systems (Garbutt & Davies, 2011: 269). Coming into conflict with utilitarianism is the dutiful clinician clinging onto the precepts of Kantian deontology.

Utilitarian administrators aim to get the most out of limited healthcare budgets through the introduction of protocols aimed at ensuring good choices through constraint. Although ensuring reasonable administrative outcomes, it places infringements on the dutiful clinician whose sole purpose is to manage his/ her patient as an end and not as a means in light of an oppressive limited budget. Protocols put into place by utilitarian administrators often have clinicians worried as to whether the confinements of such protocols would exclude patients from a particular treatment modality (Garbutt & Davies, 2011: 269). The utilitarian, although emphatic about societal welfare, recognises that harm to the individual is inevitable although regrettable in a system that justifies the greater good for the greater number. Harm in this sense, according to Garbutt and Davies (2011: 269), refers to the failure of the healthcare system to meet the needs of some patients whose treatment modalities fall outside of what utilitarian protocols determine as cost effective in striving to deliver service for the greater good to the greater number.

Healthcare is recognised by utilitarians as a greater good benefiting society and therefore requiring efficient distribution. Utilitarians, motivated by the efficient distribution of resources, are critical of clinical deontologists who despite having limited energy, concentration, resources, and money; still aim to be everything for everyone coming through their consulting doors (Garbutt & Davies, 2011: 269).

To the clinical deontologist, the maintenance of consistency in the management of patients is obligatory. Consistency is extracted from Kant's categorical imperative prescribing that we ought to act only in accordance with rules that we are willing to accept as a universal law (Van Niekerk, 2013: 26). The call to consistency stipulates that what is morally correct to do in one setting should remain the same in another. Clinicians are however unable to deliver treatment with such consistency as the imposition of utilitarian protocols aimed at limiting budgets erode treatment modalities in order to save costs.

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It is therefore evident that utilitarian and deontological precepts come into conflict when healthcare is required to be distributed fairly. In one corner one has the utilitarian administrator who aims to distribute healthcare in the most economical fashion, and in the other corner one has the deontological clinician wanting to render dutiful service that is lacking of nothing to each and every patient. A moral problem pertaining to the management of edentulism could be an expected outcome when the conflict between utilitarian and deontological view-points are scrutinised. To the deontological clinician, the aim of treatment would be in accordance with Kant's categorical imperative prescribing that we ought to act only in accordance with rules that we are willing to accept as universal laws. The implication of this in the management of edentulism, is that dentures or other appropriate forms of prostheses be constructed in order to restore adequate function and aesthetics thereby preventing the detrimental physiological and psychological effects that could possibly result. According to Kant's categorical imperative, this rule should be feasible for acceptance as a universal law. By implication its acceptance should imply consistency. Due to utilitarian limitations placed on the scope of healthcare delivery at Oral and Dental Health facilities across the Western Cape, the construction of dentures or other appropriate prostheses has been excluded. Deontological clinicians are therefore unable to render a service that prescribes to Kant's categorical imperative. Utilitarian reasoning behind the imposition of limitations on the delivery of oral and dental healthcare appears to be purely one of economics. As in the case in which it was found more cost effective to provide prophylaxis against opportunistic infections for HIV positive patients rather than the delivery of anti-retroviral treatment that would prevent HIV positive patients from developing full blown AIDS, we see that utilitarian policies could be short sighted relative to the bigger picture, therefore risking potential catastrophic outcomes. The management of HIV positive patients in South Africa was corrected against approved treatment goals and standards following intensive lobbying of government institutions. Utilitarian administrators do however recognise that even where all the long-term consequences of an intervention are properly taken into account and carefully considered, harm to individuals is inevitable although regrettable in a system that justifies the greater good for the greater number. Harm in respect of the failure to manage edentulism by healthcare facilities was discussed in Chapter 1 under the headings of physiological and psychological effects. I aim to show through extensive deliberation that the extent of this harm within communities and its impact upon individuals has to a great extent been underestimated. The question that needs to be posed is whether the utilitarian motto, the greater good for the greater number, can be upheld

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in communities greatly affected by edentulism. It is therefore the goal of this thesis to elevate edentulism as a serious condition that requires urgent attention and management.

In the following section, I introduce Norman Daniels' theory of just healthcare as a useful supplement for making decisions about interventions that a healthcare system is required to provide in light of the shortfalls discussed in classic approaches such as utilitarian and Kantian deontological moral theories.

## **5. Daniels' Approach to Health and Healthcare**

In the proceeding discussion, I will provide an overview of Daniels' approach to health and healthcare thereby providing motivation as to why his approach has been selected in the light of the shortfalls of the moral approaches discussed earlier.

A key issue evident in the structure of a healthcare system is the need to function within budgetary constraints. According to the data analysed, the application of utilitarian principles could see an increase of individuals within communities affected by edentulism as treatment at oral and dental health facilities is geared primarily towards extraction and not to perceivably more expensive procedures such as denture or other appropriate prosthesis construction. The assumption can be made that utilitarian administrators within government have determined the construction of suitable prostheses as too expensive for governmental coffers and therefore not cost effective as a treatment modality. The impact of edentulism on society, according to our assumption, is therefore not serious enough to warrant the pursuit of alternative treatment modalities. The outcomes of imposed utilitarian protocols have similar effects on other healthcare treatment modalities that fail to be recognised as cost effective in light of the need for utility.

On the other hand, the deontological clinician is unable to address this problem, as it is unrealistic to be everything to everyone in a clinical environment where constraints exist on resources.

Daniels' perspective on healthcare takes a different approach, in that he centres his emphasis not on the maximisation of utility or the performance of duty but on the protection and promotion of opportunity. Opportunity, according to Daniels, is required to allow individuals the space within which to achieve and or possibly to revise their life plans relative to others within their community. In order, to protect and maintain opportunity, normal species function is essential. I will later argue that edentulism impairs normal species function and

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therefore denies individuals a full range of opportunity. The application of utilitarian protocols in order to achieve cost effective treatment at Oral and Dental Health facilities in the Western Cape is a leading contributor to failure in the management of edentulism. The establishment of a healthcare institutional design that seeks to maintain normal species function is essential to Daniels' approach in protecting and promoting opportunity. This approach has the potential to offer new perspectives in which the management of edentulism could be seen as an important factor in the elevation of socioeconomic opportunity within poor communities.

Daniels attaches his conceptual design of healthcare to John Rawls' distributive theory of justice as fairness. He extends Rawls' principle of fair equality of opportunity through a process in which healthcare is inserted into the background of Rawls' principle thereby ensuring equitable access to a full range of opportunity in a non-ideal world (Daniels, 1981: 167). In light of this extension, it is evident that healthcare is important in the maintenance of opportunity and therefore the furtherance of socioeconomic development within communities. The link between opportunity and socioeconomic development within communities reflects the merger between Daniels' protection and promotion of opportunity and Rawls' distributive theory of justice as fairness. The application of Daniels' approach to health and healthcare could therefore bolster my argument in favour of regarding edentulism as a serious condition requiring management.

Daniels broadens his perspective on health by incorporating the unjust distribution of societal goods as influential in determining health outcomes in communities. He states that failure to distribute societal goods such as income against a distributional theory such as Rawls' justice as fairness would have serious implications for health within communities. This is based on the understanding that health is not determined primarily by the ease with which we have access to a healthcare provider but also by the cumulative effect of the distribution of societal goods.

Throughout Daniels' approach, he remains aware of the limiting effect of resource constraints in the delivery of healthcare (Daniels, 2001: 11). Daniels sets conditions whose main purpose it is to maintain fair processes that would seek to ration or set limits on resource claims. A central component to this is public involvement through deliberation (Daniels, 2001: 11). Daniels' approach to limit setting, aims to meet the goal of cooperative health

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delivery through the process of “Accountability for Reasonableness”, the purpose of which is to push decision makers toward finding reasons that all can agree upon (Daniels, 2001: 14).

Daniels thorough and fresh approach to the complexities experienced in modern medicine makes his perspective on health and healthcare design an ideal theoretical platform from which to elaborate on the complexities of my argument. I will discuss this approach in detail in the next chapter.

## **6. Conclusion**

The scope of healthcare delivery in South Africa is influenced by various moral theories and approaches. These moral systems mould healthcare in that they form the foundations from which arguments are developed that validate decisions relating to the formulation of healthcare policy. These traditional approaches to healthcare present with shortfalls that impact negatively on the delivery of healthcare.

The utilitarian perspective although noted as the efficient administrator, presents a conflicting perspective in that although it aims to uphold the welfare of society, its protocols often induce extensive harm to patient groups whose healthcare needs fall outside of that which would favour utility. In South Africa, healthcare economists follow utilitarian protocols aimed at ensuring the greater good for the greater number.

The dutiful clinician holding on to deontological perspectives finds practicing healthcare with consistency difficult in light of changing enforced utilitarian protocols aimed at ensuring the financial bottom line. Being everything to everyone entering his or her consulting room is no longer possible. This is due to limited resources required to meet the growing load of patient needs.

The shortfalls as noted within utilitarian and deontological theories, impact on the delivery of healthcare and therefore the experience of health. Daniels’ approach to just healthcare could offer an alternative here. A patient group whose treatment is excluded on utilitarian economic grounds is more likely to be assured access to treatment through Daniels’ approach to healthcare which seeks to maintain species typical function thereby ensuring opportunity. If limitations placed on treatment are inevitable, as is likely to be the case due to resource constraints, Daniels’ “Accountability for Reasonableness” approach has the potential to ensure that all role players could partake in a deliberative process in order to ensure that an amicable resolution is reached through a process of fair limit setting (Daniels, 2001: 14).

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Daniels' thorough approach to the complexities experienced in modern medicine makes his perspectives on health and healthcare design an ideal theoretical platform. His perspectives on the protection and promotion of opportunity, the impact of social influences on health, and his "Accountability for Reasonableness" approach in the light of limit setting within healthcare, makes for a well-rounded approach to health and healthcare in South Africa. I will now go on to describe these aspects of Daniels' approach in greater detail.

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## Chapter 4

### Norman Daniels' Theory of Just Healthcare

#### 1. Introduction

I concluded the preceding chapter by suggesting that Daniels' approach to healthcare has the potential to supplement the shortfalls of the classic moral theories utilitarianism and Kantian deontology. In the following chapter, I shall be presenting a detailed exposition on justice in healthcare according to Norman Daniels.

Norman Daniels' development of perspectives on justice in healthcare, at the level of ethical theory, is well known. His extension of Rawls' theory of Justice as Fairness has had a marked impact upon macro level concerns in the development of healthcare systems. These macro level concerns have to do with the scope and design of basic healthcare institutions, the central institutions and the social practices forming healthcare systems. Up until recently, according to Venkatapuram (2007: 166), philosophical discussions on health issues within industrialised countries have focussed primarily on the doctor-patient relationship and the casuistic application of the bioethics principles: non-maleficence, beneficence, autonomy, and justice. Venkatapuram (2007: 166) also states that according to various authors such as Singer, O'Neill, Sen, Shue, and Unger, philosophical reasoning about health issues in poor countries was even rarer and that discussions in these countries centred primarily on issues such as "famines, over-population, and basic needs". Daniels offers an alternative to these discussions by formulating a universalistic theoretical approach at the level of ethical theory through his philosophical consideration of divergent macro level health issues affecting both developing and developed nations (Venkatapuram, 2007: 166).

#### 2. The Foundational Question

Sessions, in reviewing Daniels' book, *Just Health: Meeting Health Needs Fairly*, states that the "foundational question" of social justice for health can be expressed as follows: "What do we owe each other to promote and protect health in a population and to assist people when they are ill or disabled?" (2008: 1310). Daniels subdivides this question into three "focal questions". His questions are as follows: firstly, "what is the special moral importance of

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health?”, secondly, “when are health inequalities unjust?”, and thirdly, “how can health needs be met fairly when it is not possible to satisfy them all?” (Sessions, 2008: 1310).

The sections in the following discussion will follow the three focal questions posed by Daniels.

Firstly, I will give an exposition of the development of Daniels’ ethical approach to health and healthcare and his extension of Rawls’ theory of distributive justice in order to answer the question as to the special moral importance of healthcare. His focus on Rawls’ notion of social goods and fair equality of opportunity forms the basis on which he develops a general principle of justice for the protection of opportunity. This general principle is foundational to the design and function of Daniels’ theory for healthcare institutions and practices.

Secondly, I will elaborate on Daniels’ perspective pertaining to the distribution of Rawls’ primary goods as determinants of health. A key point made in this section is that health is not determined by the ease of access to a healthcare provider but rather by the cumulative effect of social influences. In other words, Daniels answers the question as to when health inequalities are unjust by examining not only the influence of healthcare policy on health, but also the distribution of societal goods.

Finally, I will discuss the topic of limit setting for healthcare subject to resource constraints in order to answer the question as to how health needs can fairly be provided for when a lack of resources makes it impossible to provide for each and every health need. Rationing is required as needs cannot always be met in the manner required by some groups of people or in the way that a distributive principle would indicate.

Through considering Daniels’ answers to these three focal questions, I aim to prepare a basis upon which to evaluate the institutional design of the Western Cape Department of Oral and Dental Health Services, and particularly, their approach to the management of edentulism.

### **3. Question 1: What is the Special Moral Importance of Healthcare?**

#### **3.1. From Needs to Opportunity**

Daniels spends much energy in developing his argument in order to establish the moral importance of healthcare. He aims to determine why healthcare is morally important and which healthcare needs are most important. At the end of extensive deliberation he crystallises a conceptual formulation that establishes health as an important determinant of

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fair equality of opportunity for individuals. Included in this spectrum of opportunity is the right to pursue public offices and careers. He emphasises healthcare as a specific need which deserves priority above others because of its inherent ability in assisting individuals to achieve a range of life plans. Daniels starts his deliberation through an exposition of the concept of need in which he tries to determine what we mean by needs and which needs we are obliged to meet.

The concept of need has been expressed as being in a state of philosophical disrepute as it often presents itself as being both too weak and too strong in its essence to contribute to the development of a theory of distributive justice in that we can regard too many things or too few things as needs (Daniels, 1985: 23). In order for the concept of need to serve as a central pivot in the determination of such a theoretical framework, a clear notion of need must be determined so as to avoid seeing too many things as needs. Scanlon's development of criteria "to assess the importance of competing claims on resources in a variety of moral contexts" (quoted in Daniels, 1981: 150) may be of assistance in this regard. These criteria can be used to describe the difference between claims that we do not think we are obliged to meet, and claims that we do think we are obliged to meet, in other words, between desires and needs. Firstly, a "subjective criterion uses the relevant individual's own assessment of how well-off he is with and without the claimed benefit to determine the importance of his preference or claim" (quoted in Daniels 1981: 150). Secondly, "an objective criterion invokes a measure of importance independent of the individual's own assessment, for example, independent of the strength of his preference" (quoted in Daniels 1981: 150). The objective criterion of wellbeing is favoured in contexts of distributive justice and other moral contexts. Daniels (1981: 151) affirms this point by creating a scenario in which he requests \$100.00 from a friend. He concludes that his friend would more likely feel obligated to respond positively to his request if he needed the money for root canal (an objective criterion), rather than based on subjective criteria such as his wanting to visit his childhood neighbourhood in Brooklyn to smell pickles in a barrel. His friend might give him the money in both cases, but would only be acting out of a moral duty in the first case. A social welfare agency, however, if faced with the same request, would most likely not be at all interested in a subjective criterion as this would rely on the individual's own assessment of the importance of his request. A social welfare agency would only refer to an objective criterion in making the decision, as it would determine the level of importance of the request independent of the borrower's own preference.

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What Daniels (1981: 151) points out here is that some claims on resources are of greater importance in that they are needs and not mere desires. Such needs carry much weightier moral importance in that they are characterised by two properties. These properties can be detailed as follow. Firstly, they are objectively ascribable in that they can be ascribed to a person even if he does not realise he has them and even if he denies he has them because his preferences run contrary to the ascribed needs. Secondly, they are objectively important in that special weight is attached to claims based on them in a variety of moral contexts (Daniels, 1981: 152). Daniels includes another aspect in determining why some needs are more important than others, by referring to Braybrooke's (1968: 90) assertion that while morally important needs are not deficiencies; a deficiency of them would be detrimental to our normal functioning as human beings. Examples of such needs are our needs of food, shelter, clothing, companionship, and so on. Of note in Braybrooke's assessment of needs is that needs so determined are also characterised by properties that are objectively ascribable and objectively important.

Daniels' clear notion of the concept of need is developed on the back of Braybrooke's (1968: 90) assertion that a deficiency of specific important needs could be detrimental with regard to our ability to function as normal members of our species. Daniels therefore argues that needs important to us are those things we need in order to achieve or maintain species-typical normal function (Daniels, 1981: 153). Among these needs are healthcare needs. They are of specific moral importance because we require healthcare in order to maintain normal species functioning. They are both objectively important, in that special weight is attached to claims based on them, as well as objectively ascribable, in that an individual may not realise that he or she has them, or may even deny having them because their preferences run counter to them. A deficiency of healthcare would therefore be detrimental in that healthcare serves to protect and maintain normal species function.

Of course, meeting health needs also helps to relieve pain and suffering, the understanding of which is often used to motivate their moral importance. Venkatapuram (2007: 168) however raises Daniels' concern with respect to this ethical motivation of meeting health needs, his prime reason being that if healthcare is only required in light for its ability to reduce pain and suffering, then it will be subject to the defects of utilitarianism, the prime purpose of which is to construct maximal happiness as the only goal in life. Daniels (quoted in Venkatapuram 2007: 168) however acknowledges that contrary to the utilitarian construct of maximising happiness, health is not required to achieve every goal in life as many persons have been able

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to readjust their life plans even while having had infringements of their species-typical function. He therefore gives an alternate account that will better describe why we give such priority to meeting health needs. He states that the alternate account pivots on the following fact: “Impairments of normal species function reduce the range of opportunity open to the individual in which he may construct his ‘plan of life’ or ‘conception of the good’” (Daniels, 1985: 27). It can therefore be deduced that if individuals want to maintain opportunity in order to revise their conception of the good through time, they will need to maintain normal species function through access to healthcare (Daniels, 1985: 28). Daniels hereby establishes the need for healthcare apart from the utilitarian drive for happiness so that the central emphasis is placed on maintaining opportunity.

The discussion around opportunity relative to the individual cannot avoid reference to the notion of normal opportunity range relative to society. Daniels (1985: 33) defines normal opportunity range for a given society as “the array of life plans reasonable people in it are likely to construct for themselves”. This notion has a corporate nature in that it is socially relative to a ceiling created by an averaging of life plans as determined by reasonable people in a particular society. Factors influencing societal design, such as the stage of cultural, historical and technological development and the society’s level of material wealth, contribute to what can be determined as normal opportunity range (Daniels, 1985: 33). The normal range of opportunity for a given society is therefore representative of the full range of life plans that an individual would be likely to determine for him or herself relative to others in the same society.

To illustrate the idea of a normal opportunity range relative to society, Daniels points out that in terms of healthcare intervention, the treatment of dyslexia would be a high priority in a country with high levels of literacy, whereas in a country with low levels of literacy, dyslexia would be a low healthcare priority (1985: 35). The relative importance of healthcare needs will therefore depend upon the conditions within a given society. Daniels therefore suggests that the impairment of normal opportunity range within a given society should serve as a “crude measure of the relative importance of healthcare needs at macro level” (1985: 35). In other words, Daniels argues that we can derive the relative importance of the incorporation of a specific healthcare need into macro level planning by determining whether its absence could result in the impairment of an individual’s normal opportunity range. This is reflective of Braybrooke’s (1968: 90) assertion on needs in which he states that a deficiency of certain needs would be detrimental in that this would endanger normal species functioning.

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## **3.2. Distributive Justice**

According to Daniels (2001: 2), an effective healthcare system should stipulate the maintenance and protection of normal function as its goal, thereby contributing to the protection of opportunity. For the purposes of justice, a healthcare system should therefore be aligned with an appropriate principle of distributive justice that would seek to protect fair equality of opportunity. Daniels recognises Rawls' theory of Justice as Fairness as appropriate in his design of an effective healthcare system.

### **3.2.1. A Review of Rawls' Theory of Justice as Fairness**

Rawls' Justice as Fairness theory is based on the values of liberty and equality. Rawls thinks that we are born into inequality which is the result of natural lottery. We have done nothing to deserve our position in the natural lottery, and therefore this inequality is unfair. For this reason, Rawls thinks that we should structure society in such a way that it would work against the unfairness of the natural lottery. His theory is developed out of assumptions from which principles are derived. These principles would give rise to a basic social structure from which laws and institutions could be derived that would assure justice as fairness by its very character. The assumptions from which these principles are derived requires that individuals are free and equal, that decisions are made by rational and reasonable means, and that they are applied in a mutually cooperative fashion.

Rawls develops an initial hypothetical and nonhistorical position called the original position. Ikkos, Boardman and Zigmond (2006: 204) describe Rawls' original position as an abstract place in which everyone is equal with no conception of their position in society. From within this position individuals determine principles of justice that are fair. There are two components to the original position that assures fairness of the principles so determined. The first component, called social contract theory, affirms the acceptance of principles determined in a defined setting as chosen by rational individuals (Rawls, 2004: 55). The second component, called the veil of ignorance, brings all participants to a place of equality where they are unaware of any personal traits thereby ensuring equality in determining principles according to which they would order their society (Rawls, 2004: 55).

From within the original position, Rawls determines principles arranged in a tiered structure (Rawls, 2004: 55). The first tier describes the initial principle, known as the Liberty Principle

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in that it prescribes equality in the distribution of liberties. Its formulation states: “Each person has an equal right to a fully adequate scheme of basic rights and liberties, which scheme is compatible with a similar scheme for all” (Rawls, 1985: 227). The second tier refers to the assignment of “economic and societal benefits” (Rawls, 2004: 62). This tier is composed out of two parts. The first part of the second tier, also known as the Equal Opportunity Principle, states that “social and economic benefits must be attached to offices and positions open to all under conditions of fair equality of opportunity” (Rawls, 1985: 227). A close relation exists between the liberty and equal opportunity principles in that their contravention is not negotiable within Rawls’ theory of justice as fairness. The second part of the second tier is known as the Difference Principle. It implies that when inequalities exist in the distribution of social and economic benefits, it “must be to the greatest benefit of the least advantaged members of society” (Rawls, 1985: 227). Rawls (2004: 71) elaborates on this principle by stating that those in advantaged positions are linked to those in lesser advantaged positions in as far as when prospects improve for the most advantaged they should also improve for the least advantaged. Through this principle Rawls finds a way in which acceptable inequalities can be justified within society.

These principles, as determined from within the original position, form the foundations of Rawls’ theory of justice as fairness. Rawls however emphasises a lexical order in the application of the principles requiring that they be met in the following order: Liberty Principle first, Equal Opportunity Principle second and the Difference Principle third. In order to maintain justice, the first and second principles cannot be sacrificed in order to give advantage to the third.

In our continued discussion, Daniels’ emphasis on Rawls’ equal opportunity principle as the basis of his approach to health and healthcare will become clear.

### **3.2.2. Daniels’ Application of Rawls’ Theory in the Design of a Healthcare System**

According to Rawls (quoted in Daniels 1981: 163), society is responsible to individuals for the provision of primary societal goods. Rawls’ primary goods (Daniels, 1981: 163) include the following: “(a) a set of basic liberties; (b) freedom of movement and choice of occupations against a background of diverse opportunities; (c) powers and prerogatives of office; (d) income and wealth; (e) the social bases of self-respect”. From the list it is evident that Rawls did not include healthcare as a social responsibility that society is required to deliver. Rawls acknowledges that his theory of justice constitutes an “ideal theory” as he did

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not factor in the susceptibility of human beings to becoming ill in the real world – in other words, for the purposes of his theory, Rawls assumes a healthy population. Daniels therefore sets out to extend Rawls' theory through the inclusion of healthcare as a social good in non-ideal circumstances.

Rawls' primary good stipulating a "choice of occupations against a background of diverse opportunities" is of strategic importance to Daniels' quest of finding a route for the extension of Rawls' theory (Daniels, 1981: 165). Daniels identifies the Equal Opportunity Principle as a route through which healthcare could be introduced in an extension of Rawls' theory. Daniels suggests that healthcare provision should be included as a background institution that serves to maintain and protect fair equality of opportunity. In doing this, Daniels maintains Rawls' theory of justice in its original idealisation by ensuring that individuals remain healthy and functional in a non-ideal world while having access to a full range of life plans in a given society (Daniels, 1981: 167). Daniels' perspective on the impact of healthcare on opportunity is broader than just the opportunity to pursue a career; it encompasses "preserv[ing] for people the ability to participate in the political, social and economic life of their society" (Daniels, 2001: 2).

Daniels (1981: 168) therefore categorises healthcare institutions into four groups. Firstly, there are institutions that defend idealisation by minimising the likelihood of departures from normal function (for example, healthcare education). Secondly, there are institutions that correct departures from idealisation (for example, rehabilitation which aims to restore normal functioning). Thirdly, there are institutions that aim to maintain people in a way that is close to idealisation (for example, medical and social support services for the elderly and chronically ill). Fourthly, there are institutions that serve those who cannot be brought closer to idealisation, for example, those that are directed towards the care of the terminally ill or irreversibly disabled. Daniels (1981: 168) states that when patients reach the fourth layer due to terminal illness or severe mental or physical disability, moral virtues other than justice become apparent.

To summarise, Daniels defines health as either the absence of pathology or, more importantly, the presence of normal function. He regards the protection of normal species function as an important component of equality of opportunity, as normal function allows us to achieve "a fair share of the range of life plans in a given society" (Venkatapuram, 2007: 169). The special moral importance of healthcare, in other words, derives from the role that

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healthcare plays in protecting and promoting fair equality of opportunity. Healthcare is therefore required as a matter of justice.

#### **4. Question 2: When are Health Inequalities Unjust?**

While Daniels recognises that healthcare protects fair equality of opportunity, he also recognises that health inequalities are not only determined by access to a healthcare provider. He therefore moves on to a second question, namely, the question as to when healthcare inequalities are unjust, and argues that such inequalities are only acceptable when social goods that are determinants of health are distributed fairly.

Daniels (2001: 6) asserts that through providing access to Rawls' primary goods i.e. equal liberties, equal opportunity, fair distribution of resources, and support for self-respect; injustices in health outcomes will be reduced. He argues that causation exists between the delivery of societal primary goods and the measure of health within a given society, even when access to healthcare is fairly distributed. This is based upon the understanding that health is not determined primarily by the ease with which we access a healthcare provider, but by the cumulative effect of social influences.

A factor that greatly influences health is the distribution of income. Daniels (2001: 7) states that health is not dependent on the size of the economic pie, but on how it is distributed. Extensive research done by Wilkinson (quoted in Daniels 2001: 7) stipulates that inequality in the distribution of income across nations "is strongly associated with population mortality and aspects pertaining to life-expectancy". This was demonstrated in a study by Lynch et al (quoted in Daniels 2001: 7), in which it was found that in areas where high income inequalities prevail such as across the US metropolitan areas, more deaths occurred relative to areas with lower income inequalities.

Daniels (2001: 7) escalates his argument with the inclusion of the concept of socioeconomic gradient. The slope of the socioeconomic gradient is representative of inequality in terms of economic distribution as well as inequality in terms of health within a given society. This is particularly evident when comparing the poor health of middle income groups in countries that experience high income inequalities with the better health of poorer groups living in countries with less income inequality (Daniels, 2001: 7).

Daniels (2001: 8) also highlights the differential investment by government into human capital as a predictor of health. In developing countries a strong predictor of life expectancy

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has been determined to be adult literacy particularly in the disparity evident between male and female literacy. Low female literacy rates are strongly associated with higher mortality rates among women.

Daniels (2001: 8) summarises the downward spiral that is initiated by income inequality with resultant poor health as follow: (a) Income inequality erodes social cohesion, (b) Lack of social cohesion leads to reduced political activity; (c) Lower political participation leads to reduced governmental responsiveness “in addressing the needs of the worst off”.

Daniels (2001: 8) concludes his discussion of the impact of societal determinants on health by promoting Rawlsian principles as a guide to thinking about the distribution of social determinants. His argument suggests that even when access to healthcare is universal, health inequalities resulting from the inequitable distribution of social determinants can remain, and these are unjust unless these social determinants are distributed subject to Rawlsian principles. The application of Rawlsian principles firstly assures equal basic liberties, especially in respect of political participation; secondly, fair equality of opportunity assures “access to high quality of education, early childhood interventions”, and “universal coverage for appropriate healthcare”; and thirdly, “Rawls’ Difference Principle permits inequalities in income only if the inequalities work to make those worst off as well off as possible” thereby potentially flattening the socioeconomic gradient (Daniels, 2001: 8).

In conclusion, we see that through the application of Rawls’ principles, a fair distribution of access to healthcare and of social determinants of healthcare can be achieved. Of specific note is the application of Rawls’ Difference Principle that gives an action guide in respect of working through difficult areas such as inequalities pertaining to income. In order to maintain fairness in the distribution of social determinants, Rawls emphasises the lexical ordering of principles in the following order: the Liberty principle takes precedence, followed by the Equal Opportunity Principle and lastly the Difference Principle.

### **5. Question 3: When are Limits to Healthcare Fair?**

Daniels then turns to his final focal question, namely, what should we do to ensure fairness when not all healthcare needs can be met due to resource constraints? At the heart of effective healthcare design is the need to meet healthcare needs fairly when, as in many societies, resource constraints serve as a limiting factor. The central problem here is that needs cannot always be met in the way that particular groups of people would require or in

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the way that a distributive principle would indicate. The result is that resources such as healthcare would require rationing. Daniels (1994: 27) lists three identifiable problematic features that affect rationing decisions in the course of healthcare distribution: firstly, the goods that need to be provided are not sufficiently divisible in order to prevent unequal distribution and disappointment; secondly, when rationing, we are denying benefits to some who also have a plausible claim to having their needs met; thirdly, when rationing resources, the distributive principles appealed to by both claimants as well as rationers do not provide adequate reasons for choosing between the two parties. An example of a rationing problem is when goods such as high resolution radiographic equipment, which is extremely expensive and requires specially trained personnel to operate it, are housed at larger regional hospitals. Such equipment is not divisible – it cannot realistically be shared between larger and smaller hospitals, illustrating the first feature of rationing problems. The unequal distribution of such equipment would mean that patients, often living far afield, would have to travel long distances in order to reach regional hospitals so that they could make use of such specialised equipment. In conjunction with the unequal distribution of equipment, we are also denying benefits to some who are unable to travel far distances and who are therefore unable to have their needs met, despite having a plausible claim to these needs, illustrating the second feature of rationing problems. The third feature arises in our difficulty in choosing between claimants and rationers in this case.

In the progression of the following discussion, I shall be looking at ways in which to bridge problems that arise in reconciling distributive justice and institutional design, in other words, in reconciling theory and practice.

All societies have a responsibility to determine which healthcare needs should be prioritised and how available resources would best be spent. This responsibility requires that fair decisions be made in respect of setting just limits. Daniels (2001: 9) states that as no consensus exist on distributive principles for healthcare, we need to work at developing social policies that would assist us in determining the legitimacy of the moral authority of those making rationing decisions. Daniels develops an argument through which he aims to give clarity to a mire rich in moral controversy. He begins by discussing problems that can arise with regard to rationing in greater detail (Daniels, 2001: 9).

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### **5.1. Rationing Problems**

The first step in Daniels' argument is to point out that it is difficult to come to an agreement about principles that we could use to determine which healthcare needs require prioritising. In other words, when rationing is required, which healthcare needs should receive priority? He states that the concern for equal opportunity would seem to suggest that some priority must be given to those who are worst off (1996: 10), but this does not tell us how much priority needs to be given to the most restricted. Daniels offers possible perspectives for resolving this rationing problem. Firstly, we could call on the Maximizers position or the Maximiners position. The Maximin position requires that complete priority be given to the worst off patient while the Maximizer position indicates that we should give priority to which ever treatment produces the greatest net health benefit regardless of the patients being treated (Daniels, 2001: 9). However, in practice, the attitude of most people will fall somewhere between these two positions, allowing disagreement to remain about how we ought to resolve this question.

Daniels (2001: 10) identifies two further problems that could arise with regard to rationing. These problems suggest that we are not straight maximizers or maximiners and that we struggle to offer mediating solutions. The first of these, termed the "Fair Chances/ Best Outcomes Problem", poses the question: "should we give all who may benefit some chance at a resource or should we give the resource to those who get the best outcome?" (Daniels, 2001: 9). The second problem, termed the Aggregation problem, asks: "when do lesser benefits to many outweigh greater benefits to a few?" (Daniels, 2001: 9).

The difficulty is that there is a lack of agreement about answers to these questions, and a lack of agreement about which principles would best serve justice in healthcare provision in the context of resource constraints. Daniels therefore argues that what we need is a fair way to resolve disputes about rationing problems, in other words, that we need to "retreat to procedural justice" (Daniels, 2001: 10).

### **5.2. Procedural Justice: Accountability for Reasonableness**

Daniels contends that instead of arguing from a perspective of determining what is fair when we lack agreement on principles, we should establish and characterise the features of a fair process to resolve rationing disputes (2001: 10). He suggests a fair process, referred to as "Accountability for Reasonableness", as a structured protocol for converting "public agency

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decisions into larger public deliberation about how to use limited resources to protect fairly the health of a population with varied needs” (2001: 11). Public involvement is an essential component of this approach. This as it would allow the public to become familiar with the concept of limit setting and appropriate manners of reasoning around limit setting.

Daniels states that problems pertaining to the legitimacy and fairness of rationing decisions would be solved if the four conditions of the “Accountability for Reasonableness” approach were satisfied. The following is a brief overview of the conditions according to Daniels (2001: 11):

Publicity Condition: Decisions regarding coverage for new technologies (and other limit-setting decisions) and their rationales must be publicly accessible.

Relevance Condition: the rationales for coverage decisions should aim to provide a reasonable construal of how the organization (or society) should provide ‘value for money’ in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically, a construal will be ‘reasonable’ if it appeals to reasons and principles that are accepted as relevant by people who are disposed to finding the terms of cooperation mutually justifiable.

Appeals Condition: There is a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in light of further evidence or arguments.

Enforcement Condition: There is either voluntary or public regulation of the process to ensure that conditions 1-3 are met.

Daniels (2001: 13) states that if these four conditions are met, institutions and the decision makers in them can be held accountable for the decisions made in respect of the limits that they set. The decisions on limitations are to reflect an established procedure that displays fairness to the communities directly affected. The fairness displayed by this procedure should also display constancy over time that would allow the public to view the legitimacy of both the procedure and the decision makers. The four conditions inherent in the “Accountability for Reasonableness” approach provide suggestions that will allow for fair decision making in instances of limit setting.

Daniels concludes by stating that cooperative healthcare delivery can be met through the “Accountability for Reasonableness” approach by pushing decision makers toward finding

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reasons that all can agree upon. “Accountability for Reasonableness” will in this fashion facilitate a broader public deliberation that will be essential in the regulation of a limit setting process (2001: 14).

## **6. Conclusion**

Our discussion has determined that the application of an appropriate distributive theory is essential to ensuring the fair distribution of health and healthcare. Daniels identifies Rawls’ theory of justice as fairness as an appropriate model for making decisions around healthcare distribution based on the protection and maintenance of opportunity.

His foundational question about meeting health needs fairly is expressed as follow: “What do we owe each other to promote and protect health in a population and to assist people when they are ill or disabled?” Sessions (2008: 1310). From this foundational question, Daniels identifies three focal questions that have formed the focal point of our discussion.

In the first section, we took a closer look at Daniels’ question: “what is the special moral importance of health?” (Sessions, 2008: 1310). Daniels’ answer as to the moral importance of healthcare is derived from the role that healthcare plays in promoting and protecting fair equality of opportunity. Through our analysis we observed how Daniels extends Rawls’ fair equality of opportunity principle through a process whereby he inserted healthcare into Rawls’ theory. Daniels’ insertion of healthcare provision as a background institution serves to maintain and protect fair equality of opportunity thereby ensuring the maintenance of the idealisation of Rawls’ original design. Daniels therefore attempts to assure as full a range of opportunity as possible for all individuals within a non-ideal world through the provision of healthcare.

In the second section, we looked at Daniels’ question: “when are health inequalities unjust?” (Sessions, 2008: 1310). Daniels argued that inequalities are only acceptable when access to healthcare and societal goods that are determinants of health have been distributed fairly. He based his argument on the assertion that it is not only access to healthcare that determines health inequalities, but that inequality in the distribution of societal goods contribute to such inequalities within society. He argues that the distribution of societal goods should be subject to Rawls’ principles, namely: the Liberty Principle, the Equal Opportunity Principle and the Difference Principle. Although inequality in the distribution of income appears to be an important contributing factor to inequalities in health, he advocates that Rawls’ principles be

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followed in a lexical order in order to ensure fair and just distribution even when inequalities are unavoidable.

In the third section, we looked at Daniels' question: "how can health needs be met fairly when it is not possible to satisfy them all?" (Sessions, 2008: 1310). This question was discussed under the heading of limit setting or rationing as a result of resource constraints affecting healthcare within communities. From the foregoing discussion it is evident that a procedure should be established that would ensure fairness where agreement on rationing decisions is not possible. This procedure should involve active participation by communities in the deliberative process. Daniels' "Accountability for Reasonableness" approach provides an effective procedure in that decision makers are pushed toward finding reasons that all could agree upon. This approach will facilitate broader public deliberation that will be essential in the process of limit setting.

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## Chapter 5

### The Application of Daniels' Approach to Edentulism

#### 1. Introduction

So far, I have shown (in Chapter 2) the effects of edentulism both physically and psychosocially, and described the state of affairs with regards to edentulism in the Western Cape. In Chapter 3, I have described shortfalls pertaining to traditional approaches in health policy design and explained why Daniels' theory of just healthcare could be a useful supplement in making decisions about the kinds of healthcare interventions that we are obligated to provide. In the previous chapter (Chapter 4), I have provided an overview of Daniels' theory of just healthcare. I now turn to the central objective of this thesis – an evaluation of the Western Cape Department of Oral and Dental Health Services' approach to edentulism and the construction of dentures or other appropriate prostheses, in light of Daniels' theory.

In the following discussion I shall be applying Daniels' ethical approach for health and healthcare to edentulism. The discussion will be presented as follows. I will firstly provide a brief overview of edentulism as a failed healthcare need and the subsequent impact that it has on individuals affected by it. I will then, through extensive deliberation, present edentulism as a healthcare need required for the restoration of normal species-typical function in order to protect and maintain opportunity. I will then go on to discuss Daniels' approach to the relation between health and the broader social structure. This approach is based on his assertion that causation exists between the inequitable distribution of societal primary goods and the measure of health within a particular community. Throughout this section I shall be referencing the plight of Coloured farm-workers in the Western Cape as an illustrative example of a community which has been exposed to inequality in respect of the unjust distribution of societal primary goods. I will discuss the impact that this unequal distribution has had on their health. Finally, I will present Daniels' "Accountability for Reasonableness" approach as a foundation for procedural justice. This approach centres on public participation, ensuring that the goals of cooperative health delivery are met through a process that would push decision makers toward finding reasons that all can agree upon in the context of limited resources.

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## **2. A Review of Edentulism in the Western Cape, South Africa**

South Africa's developing economy has to deal with the constant and constrictive problem of limited resources. Healthcare as an important commodity is subject to the same constrictive effect of limited resources. To those who can afford it, private healthcare insurance offers access to various levels of medical care determined primarily by the affordability of a monthly premium. Dependence on the state run public healthcare system is the only alternative for those who cannot afford private healthcare. This translates into 18% of the population having access to private healthcare with the remaining 82% dependent on the public sector (Healthcare in South Africa, 2014).

In Chapter 2, I presented an in-depth report on the current state of affairs with regards to edentulism in the Western Cape. In the following section of my discussion, I shall review a summary of my findings so as to create a foundation against which to present my argument pertaining to Daniels' approach to just healthcare in the context of edentulism within the Western Cape. It should be noted that the patients affected by edentulism in my discussion are those originating from communities dependent on the state run public healthcare services, comprising 82% of the total South African population nationally. Data for an eight year period (2004-2011) obtained from the Western Cape Department of Oral and Dental Health Services revealed that extraction was the main treatment modality rendered at state health dental facilities. This was determined through an analysis of data obtained from dental services delivered to the prison population, which demonstrated that extraction was the main treatment modality in that for the eight year period 95 336 teeth were extracted, 655 teeth were restored and that during the same period, only 140 dentures were constructed.

The resultant effect of extensive extractions is an increase of edentulism within those sectors of society dependent on public health services. In Chapter 2, I have given an extensive description of the effect of edentulism both physiologically as well as psychosocially. An overview of the physiological effects of tooth loss intra orally reveals a reduction of denture bearing areas contributing to a loss of denture stability. In conjunction to the intra oral effects, we see that extra orally edentulism results in marked changes in facial appearance signified by an accelerated aged appearance. Extensive research into the psychosocial effects of edentulism revealed lowered self-confidence, altered self-image, altered behaviour in socialising and forming close relationships, and being more likely to feel inhibited in carrying out everyday activities.

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Adam et al (2006: 14) makes a notable assertion in this regard, stating that “the loss of all natural teeth may lead to impairment, disability and handicap” according to the World Health Organisation’s classification of these terms. I have provided further argument for this claim in Chapter 2.

A moral problem was identified, resulting from the Western Cape Department of Oral and Dental Health Services’ use of extraction as the preferred treatment modality, and their failure to provide dentures or other appropriate prostheses. This moral problem is that tooth loss, without the prospect of denture or other appropriate form of prosthesis construction, leaves a component of our community needing to cope with physiological and psychosocial challenges, often worsened by society’s imposition of discriminatory penalties. Through the application of Daniels’ ethical approach to health and healthcare, I aim to identify edentulism as an issue of social justice. My central objective in this chapter is to evaluate the Western Cape Department of Oral and Dental Health Services’ approach to edentulism and the construction of dentures or other appropriate prostheses, in the light of Daniels’ theory of just healthcare.

### **3. Edentulism and the Maintenance of Opportunity**

When questioning a group of young school going children about their future dreams and aspirations, the responses are generally varied. To some the response may be that of some high paying or prestigious job overheard in an adult conversation. To others it may be following in the footsteps of a favourite sports star. Some may be enthralled by the performing arts and would like to see themselves on stage in the glitter of lights. Responses such as these can be expected from children in all communities irrespective of their socioeconomic backgrounds. Children believe that opportunity will crystallise in order for them to realise their dreams. Dreams are ultimately the driving force to achievement.

In the course of my discussion, I aim to elevate edentulism as an issue of social justice in the context of Daniels’ ethical approach to healthcare. A central aspect of Daniels’ elaboration is the protection and maintenance of opportunity. He crystallises a conceptual formulation that establishes healthcare as a need required to maintain and protect opportunity. In doing so, healthcare becomes fundamental in assisting individuals to achieve their life plans by maintaining access to the full range of opportunity within a given society. According to Daniels (1981: 158), the full range of opportunity is a construct of all the life plans that reasonable persons in a particular society are likely to construct for themselves.

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Infringements can however occur that could constrict the life plans that individuals within a given society could construct for themselves. These infringements could be in the form of disease or trauma. Daniels' emphasis on healthcare is that such infringements, whether in the form of disease or trauma, should be treated so that normal species function could be restored. Through healthcare, individuals could therefore have access to fair equality of opportunity within a given society to the greatest extent possible. Daniels, through his emphasis on healthcare, therefore aims to ensure that each individual should have access to a full life experience through the maintenance and protection of a full range of opportunity in comparison to others in their society.

In Chapter 2, I showed that, according to the work of numerous authors, edentulism could give rise to extensive physiological and psychosocial effects. Adam et al's (2006) assertion that "the loss of all natural teeth may lead to impairment, disability and handicap" presents edentulism as a serious disadvantage in the lives of those affected. Accordingly, one can deduce that edentulism presents itself as an infringement in that it reduces normal species function. This gives rise to concern in respect of Daniels' central concept which is the maintenance and protection of fair equality of opportunity within a given society. Due to the dampening effects of edentulism, the full range of opportunity is greatly reduced. Individuals within a given society, who through access to a full range of opportunity could normally have made a positive input into the socioeconomic development of a society, would therefore be restricted in doing so due to reduced opportunity relative to others in their society.

Edentulism instils a sense of unfairness between those affected and those unaffected in light of its detrimental physiological and psychosocial effects. For example, the aged appearance resulting from edentulism results in a divergence from species-typical appearance. This non-typical appearance reduces opportunity in a number of contexts, such as the opportunity to interact socially as confidence is impacted, or the opportunity to pursue certain careers due to a lack of social acceptance. The lack of social acceptance could further be enforced through society imposing penalties which according to Deborah Rhode (2009: 1035) could far exceed what most of us could assume or would consider defensible. This was aptly demonstrated in the case of the nurse who in March 2013 was placed on immediate leave upon arrival at the hospital where she was employed following the misplacement of her dentures (Cape Town Nurse Sent Home for No Front Teeth, 2013).

The reality of edentulism is that it is an ever growing condition in respect of those dependent on the public healthcare sector. Evidence of this reality is found in data obtained from the

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Western Cape Department of Oral and Dental Health Services showing that extraction is the primary treatment modality and that denture construction is very low on the priority list of treatment modalities rendered by state health facilities. Edentulism within South Africa, as argued in Chapter 2, therefore results in impairing, disabling and handicapping outcomes for those who are affected by this condition among the 82 percent of South Africans dependent on public healthcare (Healthcare in South Africa, 2014). The debilitation induced as a result of the effect of edentulism interferes with normal species function, therefore reducing opportunity.

My emphasis from this point onwards focuses on the development of three arguments that would motivate for the avoidance of edentulism, through emphasis on treatment modalities other than extraction, and the management of unavoidable edentulism through the construction of dentures or other appropriate prostheses, within the public healthcare system.

### **3.1. Managing Edentulism, Maintaining Opportunity**

Daniels initiates his determination of the moral importance of healthcare by sifting through definitions of the concept of need. As argued in the previous chapter, Daniels' assertion that healthcare is deserving of moral importance can be supported by Scanlon's (quoted in Daniels 1981:151) discussion of needs and by Braybrooke's (1968: 90) assertion that the deficiencies of some needs could be detrimental to normal function. The moral importance of healthcare as an important need in Daniels' approach is linked to its importance in maintaining species-typical function. Daniels' approach is, however, not concerned with the utilitarian value of normal species function (in other words, its contribution to welfare) but rather with the role which species-typical function, and therefore healthcare, plays in the maintenance and protection of opportunity. Through this brief explanation of Daniels' development of the moral importance of healthcare in the protection and maintenance of opportunity, I intend to argue for the moral importance of managing edentulism in order to maintain fair equality of opportunity.

From our discussion in Chapter 2, we have established that edentulism induces extensive physical and psychosocial effects, thereby providing evidence of the debilitating effects of edentulism. This was further supported by Adam et al's (2006: 14) assertion as to the debilitating effect of edentulism in the light of the World Health Organisation's definition of impairment, disability and handicap. Adam et al's (2006: 14) assertion in respect of edentulism and its non-management holds true in light of Braybrooke's (1968:90) argument.

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Braybrooke's (1968:90) assertion that deficiencies of some needs, in this case healthcare, could be detrimental to normal functioning is evident in the debilitating effect of edentulism on an individual's normal species function. The management of edentulism via the most applicable treatment modality therefore becomes an issue of moral worth requiring urgent healthcare attention. Daniels' alternate description of healthcare as an intervention which protects and maintains opportunity emphasises the urgency of the management of edentulism. This stems from the fact that failure to manage edentulism would result in individuals having a restricted range of opportunity to pursue a variety of life plans relative to other members within their society.

The healthcare need of edentulism displays both the objectively ascribable and objectively important properties of Scanlon's conception of need (quoted in Daniels 1981: 150). We have determined that against the full range of opportunity for a given society, edentulism places a constriction on the species-typical function of the individual thereby reducing the opportunity range for the individual below the full opportunity range as determined by the societal norm. The need to manage edentulism would be determined in a way that is objectively ascribable in that it could be determined objectively in accordance with society's normal range of opportunity and not in accordance with the personal preference of a singular individual. Daniels advises that the normal societal opportunity range be used as a "crude measure of the relative importance of health needs at macro level" (1985: 35). Accordingly, one could therefore assert that as edentulism reduces the individual's share of the normal societal opportunity range, its management should be included as a healthcare need at the macro level. This should serve as a motivation for the Western Cape Department of Oral and Dental Health Services to include the construction of dentures and other appropriate prostheses into the macro plan for oral healthcare.

The need to manage edentulism via an appropriate healthcare modality is objectively important in that it is of moral significance to treat edentulism appropriately. The moral significance stems from the assertion that edentulism infringes normal species function. Failure to manage edentulism reduces opportunity for an individual relative to the opportunity range of others within the same society, and therefore impacts negatively upon fair equality of opportunity.

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### 3.2. Edentulism and Poverty

The history of South Africa is tainted by the legalisation of the apartheid system. Oppressive apartheid policies sought to favour and maintain opportunity for the minority white population. The effect of these oppressive apartheid policies on non-white communities was a greatly reduced normal opportunity range - in other words, a limiting of the range of life plans that reasonable persons within those communities would be likely to construct for themselves. This resulted in extensive poverty particularly within black and coloured communities as they were unable to partake in the shared wealth of the country. Despite the demise of the apartheid system, worsening poverty remains. Poverty and inequality in the New South Africa, twenty years after the advent of democracy, appear to have replaced the old oppressive apartheid policies, reducing the array of life plans that reasonable people in disadvantaged communities are likely to construct for themselves. Although socioeconomic policies such as affirmative action have been put in place to address inequalities of the past, severe imbalances between communities still exist. Financial advantages within some communities tend to drive opportunity.

In economically disadvantaged communities, edentulism has the potential to further compound this effect in that it reduces the opportunity range of an individual relative to that of the normal opportunity range of the community. As discussed above, the debilitating effect of edentulism, infringes on species-typical function. A lack of appropriate healthcare in managing infringements of species-typical function, in this case edentulism, would therefore reduce opportunity for individuals relative to others.

Due to political injustices in our country's past, unequal distribution of wealth has led to extensive poverty within black and coloured communities. Extensive poverty within these communities has resulted in dependence on the public sector for healthcare. Data from the Western Cape Department of Oral and Dental Health Services reflects that the construction of dentures has reduced due to limitations placed on resources at healthcare facilities, and that extraction is favoured as a cost-effective treatment modality. The result of this is that edentate individuals within these communities do not have access to appropriate public healthcare services and also do not have the financial means to pay private rates for the construction of dentures or other appropriate prostheses. The infringement of their normal species-typical function therefore reduces their opportunity to access a range of life plans.

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Reduced opportunity translates into reduced access to socioeconomic goods, resulting in increased poverty.

As previously stated, Daniels (1985: 35) advises that an impairment of the societal range of opportunity be used as a “crude measure of the relative importance of health needs at macro level”. This should serve as motivation for the Western Cape Department of Oral and Dental Health Services to include the construction of dentures and other appropriate prostheses into their macro plan for oral healthcare, as edentulism can greatly restrict opportunity.

### **3.3. Edentulism and Rawls’ Idealisation**

Daniels’ design of an effective healthcare system involves the extension of Rawls’ theory of Justice as Fairness. His extension of Rawls’ theory is based on the principle of the protection of fair equality of opportunity in a broader sense, such as “preserving for people the ability to participate in the political, social and economic life of their society” (Daniels, .2001: 2). This includes, but is much broader than, the opportunity to pursue a range of careers. Daniels inserts healthcare as a background institution that serves to promote this form of opportunity. Through the insertion of healthcare, Rawls’ theory maintains its original idealisation in a non-ideal world. In its original idealisation, Rawls’ theory of Justice as Fairness is concerned with normal, fully functioning healthy persons.

Daniels adopts a four layered approach in the insertion of healthcare as a background institution as discussed in Chapter 4. The first layer defends idealisation by preventing departures from it, the second layer corrects departures from the idealisation, the third layer maintains individuals that are close to the idealisation and the fourth layer cares for those who are terminally ill or severely handicapped. Of interest is the second layer in which Daniels aims to correct departures from Rawls’ idealisation (Daniels, 1981: 168). The type of care specified in this layer includes rehabilitative services aimed at restoring species-typical function. Functional rehabilitation of both maxillary and mandibular jaws through the construction of dentures or other appropriate prosthetic devices would be part of this range of rehabilitative services. Rehabilitation, as a motivation for the management of edentulism, therefore serves to strengthen the argument for the inclusion of denture construction into the macro planning of the Western Cape Department of Oral and Dental Health Services. The specific significance of this is that through healthcare, Daniels’ extension of Rawls’ theory of Justice as Fairness would ensure the maintenance and protection of a broader range of opportunity for communities. The construction of dentures or other appropriate prostheses

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could therefore see the restoration of a normal opportunity range for individuals within communities dependent upon the public healthcare system. However, his focus on the provision of healthcare, in this case (the construction of dentures or other appropriate prostheses) is not enough. We also need to focus on the link between socioeconomic inequalities and health inequalities. I will discuss this topic next.

#### **4. The Effect of Societal Influences on Health**

In the previous section, I concentrated on Daniels' approach to healthcare in terms of the maintenance and protection of opportunity. In this section, I will discuss Daniels' approach to the relation between healthcare and the broader social organisation. He argues that causation exists between inequitable delivery of Rawls' societal primary goods and the measure of health within a given society. This is based on the understanding that health is not determined primarily through the ease with which one has access to a healthcare provider but due to the cumulative effect of social influences. In the following discussion, I aim to show by way of example how inequality in the distribution of societal primary goods could lead to poor health. I shall be concentrating on the plight of Coloured farm-workers in the agricultural sector of the Western Cape who, as an exploration of data will show, have been on the receiving end of inequality in respect of the distribution of primary societal goods. I will make some tentative remarks about the effect that this has had on their health, with specific attention to their oral health and particularly, the incidence of edentulism.

##### **4.1 An Epidemiological Review of Edentulism within South Africa**

In the following section, I intend to give an account of the prevalence of edentulism within South Africa. According to Adam et al (2006: 7), there has been a general lack of prosthetic epidemiological data from many developing countries. South Africa has however had numerous surveys done, many among the Coloured community pertaining to denture status and treatment needs (Adam et al, 2006: 7).

Van Wyk and Van Wyk (2004: 376) in quoting from the 1988/ 89 National Oral health Survey: South Africa, states that from all the adults in South Africa aged between 34-45 years, 12.6% were totally edentulous. They also state that 3.5% within the edentulous group did not own dentures. In a population group breakdown of those totally edentate aged between 34-45, the data reveals the following: Asians 4.5%, Blacks 6.3%, Coloureds 51.6% and Whites 16.2%. These percentages, however, reveal a discrepancy in that of the total percentage of adults aged between 34-45, 19.7% are totally edentate relative to the 12.6% as

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initially mentioned. Although a discrepancy can be shown to exist, it is not sufficient to dismiss the claim that the Coloured population within South Africa is the worst affected by edentulism.

Research done by Carstens (quoted in Adam et al 2006: 9) showed that, among the farm-working Coloured population in the Boland region, 75% of the edentate farm-working population had no dentures. Reasons put forward as possible explanations for the low prevalence of denture wearing among these farm-workers were attributed to high costs, “lack of transport, limited time for treatment, absence of perceived need and unavailability of services and/ or resources” (Adam et al, 2006: 9).

The following section of my discussion aims to explore Carstens’ findings with relation to Daniels’ argument as to the link between poor health and inequality in the distribution of primary societal goods among Coloured farm-workers in the agricultural sector of the Western Cape.

#### **4.2. Coloured Farm-Workers in the Western Cape**

Fourie (2012: 2) states that the South African wine industry has been notorious for its history of bad labour relations. Although internationally known for its fine wines and varied tastes, the South African wine industry is less known for the fact that it was built on a foundation of slavery. The “dop” system, a form of slavery wherein workers were paid with liquor, continued on many farms up until as recently as the end of the twentieth century (Fourie, 2012: 2). The agricultural sector however, remains important in the Western Cape, contributing 3.9% to the economy and employing 3% of the Western Cape population in 2006 (Jacobs & Punt, 2009: 1).

In the following section, I present an overview of the labour force demographics operational in the agricultural sector of the Western Cape.

##### **4.2.1. A Demographic Review of the Agricultural Sector’s Labour Force**

In 2007 the total South African population was 47.7 million, with the population of the Western Cape at 4.8 million (Jacobs & Punt, 2009: 6). Of the total population in the Western Cape, the Coloured population was the most dominant at 2.5 million (51.8%) (Jacobs & Punt, 2009: 7).

The Western Cape is subdivided into six districts namely: City of Cape Town, West Coast, Boland, Overberg, Eden and Central Karoo. Of the six districts, the City of Cape Town

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carried the largest component of the total South African population at 3.3 million and of this total, the Coloured population was the most dominant totalling 1.5 million (Jacobs & Punt, 2009: 7). The dominance of the coloured population was also evident across all the other districts of the Western Cape.

Employment figures within the agricultural sector of the Western Cape region are as follows: 40 335 Coloured people, 24 339 African people, 8 009 White people, and 331 Indian people (Jacobs & Punt, 2009: 8). In respect of the agricultural worker's distribution across the Western Cape, it is of interest to note that Coloured households dominate five of the districts excluding the City of Cape Town that is dominated by African households. This finding can be corroborated by the fact that African migration to the Western Cape is primarily to the City of Cape Town (Jacobs & Punt, 2009: 8). Coloured households however remain the most active across the agricultural sector of the Western Cape, making up 55% of the agricultural workforce.

In the following discussion, I aim to review societal factors, such as level of education, income and wealth, which affect the agricultural sector's labour force.

### **4.3 Societal Factors Affecting the Agricultural Labour Force**

#### **4.3.1. Level of Education**

The educational levels of agricultural workers across the three racial groups (Coloured, African and White) display intense inequality (Jacobs & Punt, 2009: 26). Among the African group only 0.29% of the agricultural workers are skilled with the remaining 99.71% being unskilled (Jacobs & Punt, 2009: 26). Among Coloured agricultural workers, the skilled component is 1%, the semi-skilled 3.7% and the remaining 95.3% unskilled (Jacobs & Punt, 2009: 26). The semi-skilled within this group showed a slow increase from 0.81% in 2000 to 3.7% in 2007 (Jacobs & Punt, 2009: 26). A great disparity however exists between the groups mentioned and the White group. Of the White group, those employed in the agricultural sector are 58.1% skilled (Jacobs & Punt, 2009: 26).

Jacobs and Punt (2009: 28) points out that the overall level of formal education among agricultural workers is very low with the majority not having completed matric (84%). "According to the National Scarce Skills list of 2007 (Department of Labour), farm managers are rated as one of the most scarce skills in South Africa, while agriculture technicians, plant operators, crop farm-workers and livestock farm-workers also appear on the list" (Jacobs & Punt, 2009: 30). The presence of such a marked skills gap between the race groups indicate

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that an injustice is being perpetuated amidst a very present need for skilled agricultural workers according to the National Scarce Skills list of 2007 (Department of Labour). The immensity of this injustice is reflected in the fact that 95.3 % of Coloured and 99.7% of African farm-workers are unskilled (Jacobs & Punt, 2009: 26). This has an immense effect on the financial wellbeing of households as the next section will show.

#### **4.3.2. Income**

For the period 2000 through to 2007, the individual median income of African and Coloured groups remained relatively unchanged at R950.00 per month (Jacobs & Punt, 2009: 38). The income of the White groups however showed a variable increase. Income dips did however occur for this group in the years 2002, 2004 and 2006 (Jacobs & Punt, 2009: 38). These dips were negligible as the increases in the years following compensated sufficiently to dismiss the effect of the dips. The median income range for individuals within the White group started off at R4000 per month and increased to R7000 per month for the period 2000 through 2007 (Jacobs & Punt, 2009: 38).

The low income among Coloured and African agricultural workers contributed greatly toward a series of farm-worker strikes that started on 27 August 2012 with the potential of destabilising the entire sector. These strikes were inspired by the “Marikana Massacre that occurred on 16 August 2012, where the South African Police Service (SAPS) opened fire on striking mineworkers, killing 34 workers” (The Western Cape Farm-workers Strike 2012-2013).

The epicentre of the agricultural workers’ strike was on the Keurboschkloof Farm near De Doorns in the Cape Winelands District where workers, predominantly women, reacted to “new farm owners who wanted workers to sign contracts, stipulating lower wages” (The Western Cape Farm-workers Strike 2012-2013). The farm-workers demanded an increase of the minimum daily wage from R69.00 to R150.00 (The Western Cape Farm-workers Strike 2012-2013). The outcome of their demand was a R36.00 increase, effectively increasing their daily minimum from R69.00 to R105.00 (Davis, 2013). This was as per an announcement made by the Labour Minister, Mildred Oliphant, as to the new agricultural sector wage determination effective as from March 2013 (Davis, 2013).

#### **4.3.3. Wealth**

In the year 2000, the South African Government set the poverty line at R322 per adult equivalent (over 15 yrs) per household per month (Jacobs & Punt, 2009: 47). The amount

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totalling R322 per adult equivalent per household per month, although complex in its calculation could be demonstrated in its simplest form as R211 spent per month on essential food per adult equivalent and R111 spent per month on essential non-food items per adult equivalent (Statistics South Africa National Treasury, 2007). Against the 2006 prices, the poverty line has been increased to R431 per adult equivalent per household per month (Statistics South Africa National Treasury, 2007).

In 2007, the headcount ratio of the total population of South Africa living below the poverty line equated to 44.57% (Jacobs & Punt, 2009: 47). This translated into a figure of 21 million South Africans. Headcount poverty ratios for the greater South Africa in 2007 showed that the African group accounted for the highest share of poverty at 86.63% with the least poverty affected being the Indian group standing at 1.7% (Jacobs & Punt, 2009: 47). This translated into 18 million African people earning less than R322 per month per adult equivalent and a figure totalling 361 164 for the Indian population group (Jacobs & Punt, 2009: 47).

These figures change considerably for the Western Cape agricultural households. 2007 Statistics show that the most dominant group affected by poverty in the agricultural sector is the Coloured population with 66.12% of the headcount poverty ratio (Jacobs & Punt, 2009: 49). This translates into 2 606 households. The African group maintains 34% of the headcount poverty ratio while the White group displays an approximate 5% of the headcount poverty ratio (Jacobs & Punt, 2009: 49).

Another point of interest, according to Jacobs and Punt (2009: 43) is the number of beneficiaries per household in the agricultural sector. Jacobs and Punt (2009: 43) points out that Coloured households contain the most beneficiaries (275 415), followed by African households (66 147) and lastly White households (33 619) in 2007. Beneficiaries in this context refer to individuals within households who are dependent on often a single household income. Although the trend (number of beneficiaries) appears to have decreased, Jacobs and Punt (2009: 43) are of the opinion that this is not a true reflection. They reason that the decreasing trend up until 2007 does not necessarily indicate smaller households or household sizes within the agricultural sector, but rather that the declining trend “is an indication of the decreasing trend within employment, signifying a decrease in beneficiaries due to lower employment in the sector” (Jacobs & Punt, 2009: 43). In other words, with a decrease in the number of Coloured farm-workers employed on farms, the overall data would reflect a decrease in the number of dependents as the principle member within the household is

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responsible for his/ her dependents. The result of which is an increase of poverty as no-one is earning an income.

#### **4.4. The Relationship between Societal Goods and the Measure of Health within a Society**

From the above discussion it is evident that the Coloured group within the agricultural sector is the worst-off. This is due to injustice in terms of the distribution of societal goods such as education, income and wealth. Daniels argues that causation exists between the delivery of societal goods and the measure of health within a given society. This is based on the understanding that health is not determined primarily by the ease with which we have access to a healthcare provider but due to the cumulative effect of social influences.

Wilkinson reported (quoted by Daniels 2001:7) that inequality in the distribution of income across nations “is strongly associated with population mortality and aspects pertaining to life-expectancy”. Daniels (2001: 7) clarifies this statement by stating that health is not dependent on the size of the economic pie, but on how it is distributed among all within a given society. The distribution of income within the agricultural sector displayed an intense inequality when comparison was made between the income of the Coloured group, averaging R950 per month over an eight year period, and the White group whose income for the same period increased from R4000 to R7000 per month. Lynch et al (quoted in Daniels 2001: 7) demonstrated, from research done in metropolitan areas across the US, that where high income inequalities prevailed, more deaths occurred relative to areas with lower income inequalities. Similar findings to Lynch et al’s research have been demonstrated in the South African context through the work of Sparrow, Ortmann, Lyne and Darroch (2008: 65), who stated that within the South African context the average life expectancy has decreased from 63 to 48 years of age in the 15 year period spanning 1989 through to 2004. They stated that the rural poor, who supply most of the country’s agricultural labour, have a high incidence of HIV/ AIDS contributing to the decrease in life expectancy. Sparrow et al (2008: 65) states that as many as 5 000 people die every week in South Africa from AIDS and AIDS-related diseases. Although no direct life expectancy figures are available for Coloured farm-workers in the Western Cape, the data as provided by Sparrow et al (2008: 65) shows a direct correlation with the research outcomes of Wilkinson and Lynch et al (quoted in Daniels 2001: 7) in respect of the relationship between high income inequalities and increased mortality among lower income groups.

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Research by London, Nell, Thompson and Myers (1998: 1101) provides a background which reveals factors contributing to the health needs of farm-workers, which in turn contribute to a decreased life expectancy. Data confirming high patterns of alcohol intake in London et al's (1998: 1100) study determined that in excess of 68% of their sample population would be identified as alcoholic. London et al (1998: 1100) also found that 20% of the farm-workers in their study were receiving alcohol as payment while in employment. This finding by London et al (1998: 1100) supports Fourie's (2012: 2) statement that the "dop" system was practiced as recently as the end of the twentieth century. Of interest is the fact that this practice occurred on farms not producing wine or grapes. On farms where workers were still receiving alcohol, the risk of pesticide poisoning was also higher (London et al, 1998: 1100). London et al (1998: 1100) also determined that due to extensive alcohol consumption, social ills such as alcohol-related trauma and domestic violence placed additional burdens on already under-resourced rural health services. London et al's (1998: 1100) findings therefore provides evidence for the similar research outcomes of Wilkinson and Lynch et al (quoted by Daniels 2001:7) in respect of the relationship between high income inequalities and increased mortality among lower income groups such as Coloured farm-workers in the Western Cape. Daniels (2001: 8) presents the relationship between high income inequalities and increased mortality among lower income groups as a downward spiral whose progression follows the following route: (a) Income inequality erodes social cohesion, (b) Lack of social cohesion leads to reduced political activity, and (c) Lowered political participation leads to reduced governmental responsiveness "in addressing the needs of the worst-off".

Daniels (2001: 7) introduces the concept of the socioeconomic gradient as a slope that is representative of inequality in terms of economic distribution and health within a given society. The poor distribution of societal goods among the Coloured farm-workers would be representative of a sharp gradient reflecting intense inequality both economically and in respect of health. In relation to the sharp gradient evident in the Western Cape agricultural sector, Carstens' (quoted by Adam et al 2007: 9) finding that 75% of the edentate farm working population had no dentures could be reflective not only of the failures of the public health service, but also of the bigger problems that these people are having to cope with on a daily basis. Within this community, we see that pressing daily concerns could reduce the priority placed on denture construction in the management of edentulism within this community. This does not, however, negate the objective importance of managing edentulism as indicated by Adam et al's (2007: 14) assertion that edentulism is an

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impairment, disability and handicap. In addition to the assumption made in respect of the Coloured community's low priority ranking of the management of edentulism, we see that government has reduced its responsiveness in addressing the needs of communities, in this case through the cessation of certain oral healthcare services such as denture construction and the prioritization of extraction as a treatment modality. As edentulism is not managed within the community, the debilitating effects of edentulism become common and therefore seem to be of no consequence.

In the preceding discussion, we see that due to the poor distribution of societal goods, health inequalities have resulted. According to Daniels, the poor distribution of societal goods are unjust unless societal goods are distributed according to Rawlsian principles (Daniels, 2001: 8). The application of Rawlsian principles firstly assures equal basic liberties especially in respect of political participation; secondly, fair equality of opportunity "assures access to high quality of education", and "universal coverage for appropriate healthcare"; and thirdly, "Rawls' 'Difference Principle' permits inequalities in income only if the inequalities work to make those worst off as well off as possible" thereby potentially diminishing the socioeconomic gradient (Daniels, 2001: 8). In the experience of Coloured farm-workers, the application of Rawls' Difference Principle would ensure a fair and just distribution of income as inequalities in income would only work to make those worst off as well off as possible.

What this discussion shows is that the management of edentulism cannot be considered in a vacuum. The construction of dentures or other appropriate prosthetic devices by the public health service is morally necessary as argued in the previous section, but this alone will not resolve the issue of healthcare inequality in terms of oral healthcare in the Western Cape. As Daniels argues, healthcare inequalities are also the result of injustice in the distribution of other social goods, and this has been illustrated by the example of Coloured farm-workers in the Western Cape. This issue requires further consideration and is beyond the scope of the present discussion, but as Daniels argues, Rawlsian principles could be of use here.

## **5. Factoring Rationing into Edentulism**

At the heart of effective healthcare design is the need to meet healthcare needs fairly. The problem central to this is that needs cannot always be met in the way that particular groups of people would require or in the way that a distributive principle would indicate. Key to the issues involved are resource constraints, which necessitate the rationing of resources in order

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to determine a fair process of distribution. As previously discussed, Daniels (1994: 27) lists three identifiable problematic features that affect rationing decisions in the course of distributing healthcare: firstly, the goods that need to be provided are not sufficiently divisible in order to prevent unequal distribution and disappointment; secondly, when rationing, we are denying benefits to some who also have a plausible claim to having their needs met; and thirdly, when rationing resources, the distributive principles appealed to by both claimants as well as rationers do not provide adequate reasons for choosing among claimants.

## **5.1. Moral Theories in the Background to Rationing**

Before having a closer look at processes that would help to reduce the mire of moral controversy surrounding rationing, I aim to reflect on the foundational moral aspects that often require untangling in order to clear the path for reasoning on the topic of rationing. Macro level planning of healthcare institutional design and micro level planning of healthcare distribution at the clinician/ patient interface brings two moral theories into conflict. These moral theories namely, utilitarian and deontology, more often than not assume opposing positions in the sphere of healthcare planning. Although opposing in their perspectives, they are of fundamental importance in that together they improve the delivery of healthcare, from administration to clinical care. The ultimate aim of these moral theories being to provide a healthcare service that is a collective good benefiting both society and its members (Garbutt & Davies, 2011: 269).

### **5.1.1. Utilitarianism**

Utilitarianism has been called the efficient administrator of medical systems by Garbutt and Davies (2011: 269). This is achieved through the introduction of protocols aimed at ensuring good choices through constraint, thereby aiming to promote clinical efficiency and cost effectiveness. The introduction of such protocols are often not broadly accepted by those in clinical practise, however from an administrative perspective, it presents as a reasonable option at maintaining the economics of healthcare. The most cost effective treatment aimed at ensuring healthcare economics could result in a large component of society being neglected as their need for healthcare could be outside of what is determined cost effective. This holds true for individuals who as per our discussion require the construction of dentures or other appropriate prostheses. These individuals are left without their healthcare need being

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met as the only healthcare system available to them fails to cater for their particular health need.

### **5.1.2. Deontology**

In contrast to utilitarianism being presented as the efficient administrator, deontology is presented as the dutiful clinician aiming to treat every patient as an end and not as a means (Garbutt & Davies, 2011: 268). Treating each patient according to their healthcare need through treatment modalities which according to the clinician will deliver the most effective outcomes, is the goal of each deontological clinician. This would however only be possible in a utopian world where healthcare could afford to meet the need of each patient free of resource constraints. Utilitarians, however, assert that as there are too many patients requiring healthcare for providers to treat each patient as though they are the only in need of treatment. Against factors such as the cost to the public health sector and the reasoning that the management of edentulism is not important enough, deontological oral health practitioners are unable to render appropriate treatment. The call is therefore to provide resources effectively from both the perspective of the healthcare administrator as well as from the healthcare provider in order to meet healthcare needs effectively and fairly.

### **5.2. Rationing and Edentulism: Towards Accountability for Reasonableness**

Statistics obtained from the Western Cape Department of Oral and Dental Health Services over an eight year period confirmed that the leading treatment modality practiced by most dental clinicians at state health facilities was extraction, and that very few dentures were constructed. The result of this is an extensive increase in edentulism within communities dependant on public healthcare facilities. This outcome was the result of utilitarian protocols employed by the Western Cape Department of Oral and Dental Health Services, which have placed constrictions on treatment modalities in order to save costs at community health facilities. As discussed in Chapter 2, individuals within these communities are therefore subject to the debilitating effects of edentulism. In light of the fact that healthcare cannot always be met in the way that particular groups of people would require, a process of deliberation is required in order to investigate what has appeared to be a unilateral decision to ration the service of denture or other appropriate prosthesis construction by the Western Cape Department of Oral and Dental Health Services.

As described in Chapter 3, Daniels suggests that when decisions need to be taken about rationing in the light of resource constraints, and where there is a lack of agreement about the

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fairness of these decisions, we should turn to an approach which will assure procedural justice in the decision-making process. He advises a process of procedural justice referred to as the “Accountability for Reasonableness” approach.

Problems pertaining to the legitimacy and fairness of rationing could be solved if the four conditions of the “Accountability for Reasonableness” approach were in place (2001: 11). To reiterate, these conditions are as follows. The first condition, namely the Publicity Condition, requires that when a decision needs to be taken in respect of rationing, the rationale for that decision should be accessible to the public. The second condition, namely the Relevance condition, requires that the rationale given by public agencies in respect of the cessation of a particular healthcare modality should be determined as mutually justifiable by communities who would be directly affected by reasonable resource constraints. The third condition, namely the Appeals condition, allows for a process in which rationing decisions could be challenged, and/or in which dispute resolution regarding rationing decisions could be catered for, “including the opportunity for revising decisions in light of further evidence or arguments.” The fourth condition, namely the Enforcement condition, ensures that through a public regulation of the process, conditions 1-3 should be met.

The application of Daniels’ (2001: 11) “Accountability for Reasonableness” approach in the management of edentulism would have at its core public participation. Public participation would ensure that health issues such as edentulism would not be discarded without debate as an inessential healthcare need as a result of utilitarian protocols promoting cost effectiveness. I will discuss each of the conditions of this approach with relation to their application to the management of edentulism by the Western Cape Department of Oral and Dental Health Services.

The publicity condition of the “Accountability for Reasonableness” approach could be used to disperse limit setting rationales as determined by the Western Cape Department of Oral and Dental Health Services to community elected ward councillors, who could then obtain public opinion. From the Western Cape Department of Oral and Dental Health Services’ data, it is apparent that the rationales requiring comment include the promotion of extraction as the main treatment modality and the public health’s cessation of denture construction.

The relevance condition would resolve that decisions made are mutually justifiable in that reasonable fairness is taken into consideration from both the side of the public organ (such as the Western Cape Department of Oral and Dental Health Services) in needing to cope with

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resource constraints, as well as from the community's requirement of having a healthcare need met which in this instance means the management of edentulism.

The appeals condition ensures that the infrastructure developed to ensure participatory decision making would be in place. This condition allows for a system that would cater for dispute resolution and or the challenging of rationing decisions or, alternatively, revising decisions made in light of further arguments or new evidence. In respect of treatment rationales enforced by the Western Cape Department of Oral and Dental Health Services pertaining to the construction of dentures and other appropriate prostheses, the appeals condition would provide an avenue that would allow for the revision of decisions undertaken in light of further arguments such as those presented in this thesis. This would include Daniels' argument in which he maintains that healthcare is associated with a moral responsibility to restore normal species-typical function in order to protect and maintain fair equality of opportunity within a given community. The argument motivating for the construction of dentures or other appropriate prostheses would therefore be able to provide for a new perspective other than the classic utilitarian and deontological perspectives.

The enforcement condition ensures that the three preceding conditions are met. This is attained primarily through public participation as the core ideal to Daniels' "Accountability for Reasonableness" approach. Through public participation, the goals of cooperative health delivery can be attained in that all participants would be represented in it. This would allow for the formulation of just reasons pertaining to rationing (Daniels, 2001: 14).

## **6. Conclusion**

In the preceding discussion I have applied Daniels' ethical approach for health and healthcare to edentulism. From our discussion I have firstly concluded that the construction of dentures or other appropriate prostheses is required in order to restore normal species-typical function so that the full range of opportunity in a given society could be both protected and maintained. Secondly, I concluded that although it would be a moral necessity to construct dentures or other appropriate prostheses, this in itself would not reduce ill health within communities where societal goods were unjustly distributed. Daniels argues that causation exists between the inequitable distribution of societal primary goods and the measure of health within a particular community. He advises that these societal goods be distributed against Rawlsian principles. Thirdly, I concluded that in instances where rationing of resources such as healthcare were unavoidable, the application of Daniels' "Accountability

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for Reasonableness” approach would provide for a fair process in which all participants affected by the process of decision making would be represented.

## Chapter 6

### Conclusion

The prevalence of edentulism is growing within a large sector of the Western Cape, primarily because of the public health sector's promotion of extraction as its favoured treatment modality and its failure to manage edentulism through the construction of dentures or other appropriate prostheses. Through extensive deliberation, I have shown that edentulism can cause severe physiological and psychosocial effects.

These detrimental effects reduce normal species-typical function, thereby reducing an individuals' access to a full range of opportunity relative to others within a given community. Daniels' maintains that society has a moral responsibility to restore normal species-typical function in order to protect and maintain fair equality of opportunity within a given community. The management of edentulism through the construction of dentures or other appropriate prostheses, although not reducing all physiological and psychosocial effects, dramatically improves function and aesthetics. In doing so, fair equality of opportunity is both protected and maintained in individuals with a reduced share of normal societal opportunity range. An application of Daniels' theory reveals that the management of edentulism should therefore be included as a health need in macro level planning. This thesis has therefore argued for the need to promote the construction of dentures or other appropriate prostheses in the Western Cape Department of Oral and Dental Health Services' macro planning for oral health.

Daniels however advises against the assumption that improving healthcare provision would necessarily reduce socioeconomic and health inequalities within a community. He argues that a link exists between socioeconomic inequalities and health inequalities. As an illustrative example, I have used the Coloured farm-worker community to explain Daniels' argument. This group has been subject to the unjust distribution of societal goods such as education, income and wealth. In accordance with Daniels' argument, this group is also subject to severe health inequalities ranging from decreased life expectancy to intensive social ills as the result of alcohol related trauma and domestic violence. The provision of dentures or other appropriate prostheses, although morally necessary, would however not resolve healthcare inequalities resulting from the unjust distribution of societal goods. Daniels advises that societal goods should therefore be distributed according to Rawlsian

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principles. This suggestion deserves further consideration which is beyond the scope of this thesis.

A final aspect to this thesis is the application of Daniels' "Accountability for Reasonableness" approach to the management of edentulism. As identified in Chapter 3, utilitarian policies often place infringements on the delivery of specific healthcare modalities primarily from an economic management perspective. Daniels' "Accountability for Reasonableness" approach makes up for some of the shortfalls of this approach by allowing for procedural justice in the application of fair rationing. A core aspect to this approach is public participation, so as to ensure that the goals of cooperative health delivery can be met. Through this approach, decision makers are brought to a place where all can participate in determining what a fair process would entail if rationing were to be instituted. In respect of the moral need to manage edentulism through the construction of dentures or other appropriate prostheses, and in a context where the public health sector has already stopped the construction of dentures, the appeals condition within Daniels' "Accountability for Reasonableness" would allow for the challenging of rationing decisions where new evidence or further arguments have been brought to light.

In final conclusion, this thesis has attempted to shed light on a new perspective in managing edentulism as a healthcare problem. It has done so through the utilisation of Daniel's approach to health and healthcare as an ideal platform for dealing with the moral challenges associated with the management of edentulism.

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