The Many Faces of Health Justice

Sudhir Anand
International Inequalities Institute,
London School of Economics

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International Inequalities Institute

The London School of Economics and Political Science

Houghton Street

London

WC2A 2AE

Email: Inequalities.institute@lse.ac.uk

Web site: www.lse.ac.uk/III

@LSEInequalities

Abstract

This paper develops the idea of health justice as a plural conception. It draws on the literature on justice from philosophy and economics, and investigates its application and reach in the space of health. Several distinctions are invoked in identifying and contrasting different facets of health justice and injustice. These include active versus passive injustice; process fairness versus substantive justice; comparative versus non-comparative justice; compensatory and distributive justice. Within distributive justice, the health implications of alternate principles – viz. equality, priority, sufficiency, and efficiency – are examined and evaluated. Many faces of health justice are thus exposed which help to address the varieties of injustice observed in the health sphere.

1. Introduction

The Covid-19 pandemic has exposed and exacerbated many inequalities and inequities that have been embedded in societies. The impact of the outbreak has been very unequal across population groups within a country, and between entire countries. With the pandemic causing millions of severe illnesses and avoidable deaths, it is natural to ask what justice requires to deal with these issues.

In an earlier paper I tried to analyze the risk factors and health consequences for a population group in six stages of progression of Covid-19 (Anand 2021). The framework developed there allowed us to understand the source and nature of disadvantage suffered by different groups in the incidence of the disease. This paper steps back from those issues relating to Covid-19; it is instead concerned with wider conceptual questions underlying any discussion of justice in health.

How do people recognize a health injustice? How *should* it be recognized? Has Covid-19 been a case of misfortune (bad luck) or of injustice? What is the nature of the different injustices that have led to a disproportionate incidence of the disease? Is the widely-used concept of health equity adequate to understand the many health injustices that have arisen before and during Covid-19? Can we provide a concise definition of health justice? To address such questions, we need to have a grounded conception of health justice and injustice. This paper aims to achieve that through a comprehensive investigation of the idea of health justice.

Discussion of the two topics that motivate this paper – a global pandemic and a definition of justice – originated at the same place and time about 15 centuries ago. The first recorded account of a global pandemic in history and the first codification of a definition of justice happened at around the same time, circa 540 CE, in Constantinople under the reign of the Byzantine Emperor Justinian I. Section 2 of the paper traces the common link back to the Plague of Justinian and the *Institutes of Justinian*, a Roman Law text which contains the first codified definition of justice – viz., *suum cuique tribuere* – to render to each person his “due”.

Section 3 of the paper takes up the question of how injustice is recognized through our feelings and experiences – the anger we feel when we do not get what we believe is our “due”. In order to understand justice, it is suggested that we need to put injustice first. This section also takes up the questions of active versus passive injustice, misfortune versus injustice, and whether Covid-19 is a misfortune or an injustice.

Section 4 asks why we need a concise definition of health justice, when it is manifestly such a broad-ranging, multifaceted, and complex concept. A precise and comprehensive definition may not be possible, but an ostensive definition could serve to describe the concept through examples.

Section 5 asks whether issues of justice should be resolved by people's common beliefs about justice rather than by some ideal theory of justice. 'What the people think' or 'conventionalism', is of relevance, but can an empirical approach to justice substitute for a normative justification of the concept?

Section 6 starts by noting several conceptions or principles of justice discussed in the philosophical literature, most of which can be mapped to the health space. There are many varieties of justice which deal with different and contrasting aspects of the concept. A brief review is provided before they are discussed individually in later sections. The term "currency of justice" is adopted to denote the object or variable in terms of which advantage and deprivation are assessed in a theory of justice.

Section 7 contrasts two of the most influential works on justice in the past 50 years – Rawls (1971) and Sen (2009) – in terms of their respective implications for justice in health. The differences centre on five features: institutions versus the lives that people actually lead; perfect versus comparative justice; primary goods versus capabilities as the currency of justice; the nature of impartiality in the assessment of justice; and limitation of the scope of justice to the sovereign state.

Section 8 discusses the important distinction between process fairness and substantive justice. Process fairness refers to fair treatment (including the procedures used) in arriving at final outcomes, whereas substantive justice refers to justice of the final outcomes themselves. A critical application of this distinction is examined in a subsection on the equalization of life expectancy of women and men, sought by some strict egalitarians.

Section 9 discusses another distinction, that between comparative and non-comparative justice. Justice takes a comparative form when determining what is "due" to a person depends on what might be due to other people. It takes a non-comparative form when what is due to a person is determined solely by the relevant facts about that person. Thus, health equality or 'equity' is a comparative principle, but health 'sufficiency' is non-comparative because it is simply concerned with a person having 'enough' (e.g., health care) – without reference to anyone else.

Section 10 discusses three different principles of distributive justice in separate subsections – equality, priority, and sufficiency. Equality is demanded in some form by every theory of justice, but the question is "equality of what?". Whatever is considered as the currency of justice, a central objection to pursuing equality for its own sake is the "levelling-down objection" – for example, bringing down the life expectancy of women so that it equals that of men. The levelling-down objection is asserted as a reason for rejecting pure egalitarianism in favour of prioritarianism – or assigning priority to the worse off. This can be done through weighting schemes that assign continuously diminishing weights on the level of the variable of interest (health) throughout its range, which also incorporates a concern for equality. The other distributive principle that is contrasted with

equality is 'sufficiency', which is mentioned in Section 9 as an example of non-comparative justice. But sufficiency raises other distributional issues, both below and above the sufficiency threshold (or 'health poverty' line).

Section 11 examines the relationship between health inequality, health inequity, and health injustice. The influential and widely-used definition of health equity (viz. 'health *differences* that are unjust') puts it firmly in the category of comparative justice. But health justice is a much wider notion that encompasses *all* comparative and non-comparative assessments of justice (e.g., health sufficiency and aggregate health). A Venn diagram is presented to show the relationship between health inequalities, health inequities, and health injustices. One type of health inequity concerns 'health gradients' by SES class, popularized by the Commission on Social Determinants of Health. A subsection examines health gradients in relation to aggregate health, which is a non-comparative aspect of health justice, and discusses the possible tension between them.

Section 12 is a brief concluding comment on the many faces of health justice. An explicitly plural view of health justice is necessary to address the disparate types of health injustice and unfairness that are observed in the world. The project of health justice is concerned with the identification, diagnosis and redress of such diverse health injustices.

2. The first global pandemic and definition of justice

The first documentation of a global disease pandemic and the first codification in the Law of a definition of justice happened in the same decade around 540 CE, and under the aegis of the same person, the Byzantine Emperor Justinian I in Constantinople. What was to become a global pandemic was named after him as the Plague of Justinian (c. 541 CE) because he was a victim of the disease – although he survived it. The first codified definition of justice is contained in *The Institutes of Justinian*, a compilation of Roman Laws and legal principles enacted by Justinian (r. 527 – 567 CE).

The Plague of Justinian was recorded by Justinian's court historian Procopius in his *History of the Wars*, Book II.22 and in his *Secret History* (Mark 2020).[1] The plague is thought to have originated in China and northeast India, and was carried to the Great Lakes region of Africa via overland and sea trade routes. Procopius identifies the point of origin of Justinian's plague as Pelusium on the River Nile's northern and eastern shores, from where it entered Constantinople through trade – most likely arriving with flea-ridden rats on grain ships out of Egypt (Rosen 2007). Once aboard the grain boats and carts the rats were carried throughout the empire, and the pandemic continued to

[1] There appear to be no records of earlier *pandemics*, although there is some evidence of earlier *epidemics* such as the 'plague of the Philistines' mentioned in the Old Testament or the 'plague of Athens' of 430 BCE described by Thucydides.

sweep the Mediterranean world for another 225 years – disappearing finally in 750 CE (Little 2007).

The disease attacked people indiscriminately and over the years Justinian's plague, also known as 'The First Plague', claimed the lives of millions of people; most scholars estimate the number of deaths at between 30 and 50 million. Procopius, in his *Secret History*, describes victims as suffering from delusions, nightmares, fevers, and swellings in the groin, armpits, and behind their ears. Many victims suffered for days before death, while others died almost immediately after the onset of symptoms. Procopius' description of the disease almost certainly suggests the presence of bubonic plague (*Yersinia pestis*) as the main culprit of the outbreak (not pneumonic or septicaemic plague).[2] This is confirmed by contemporary DNA analyses carried out on bones found in graves.

Procopius in his *Secret History* is highly critical of Justinian's response to the outbreak and condemns his reign as unjust and capricious. He notes that even when the plague was raging with thousands of people dying every day, Justinian demanded the same total levy of taxes from his decimated population – charging survivors exorbitant rates to make up for those who had died. These taxes went to Justinian's building projects, not as provision for the sick and dying from the plague. The projects were public works and church building projects, including the Hagia Sophia cathedral in Constantinople – now a UNESCO World Heritage Site.

Although Justinian sometimes gets a bad press as a misguided autocrat, there is no dispute about his extraordinary achievement in the legal sphere. Beginning within months of his accession as Emperor, he oversaw not only the publication of a revision and updating of existing late Roman legislation, but also a suite of other legal works, including a new set of prescriptions for legal education (Honoré 2010). The latter, published in 535 CE, is known as the *Institutes of Justinian*, which is a textbook for law students that is still in use today at universities teaching courses in Roman Law.

The Institutes of Justinian declares that "the whole of our law relates either to persons or to things or to actions". It has been translated from its original Latin into English (and other languages) by several legal scholars over the ages. The very first sentence of the *Institutes* is a definition of justice in Latin (English translation is shown immediately below):

"*Iustitia est constans et perpetua voluntas ius suum cuique tribuens*."

[2] After the Third Plague erupted in the cities of China and India in the 1890s, the recently-developed scientific techniques of bacteriology and pathology were applied to isolate the organism by Alexandre Yersin (a Swiss student of Louis Pasteur) and at almost the same time by Shibasaburo Kitasato (a Japanese student of Robert Koch), both working in Hong Kong. The organism was isolated in 1894 as a bacillus by both Yersin and Kitasato, and named after Yersin as *Yersinia pestis*. Yersin also showed that rats were carriers of the disease, and Paul-Louis Simond in 1898 showed that plague was transmitted from rodents to humans by fleas.

"Justice is the constant and perpetual will to render to each his due."[3]

The phrase *suum cuique tribuere* – to render to each his "due" – is the core idea that runs through almost all the various conceptions of justice that have been proposed.[4] Although quite abstract in this form, what is "due" is specified differently in different theories of justice and in different practical contexts. It will form a recurrent refrain in this paper in relation to health justice.

3. Putting injustice first

Conventional concerns with unfairness or undeserved outcomes often centre around the expression 'injustice' and its 'redressal'. The sense of injustice is a powerful motivational force, unlike the sense of justice which tends to be conceived in more abstract ways. Injustice arouses our anger, whereas justice is a rather cold virtue which can be manifested without feeling.

The role of the sense of injustice has been extensively explored by the Harvard political philosopher Judith Shklar in her book, *The Faces of Injustice*. According to Shklar (1990, p. 83) the sense of injustice is "the special kind of anger we feel when we are denied promised benefits and when we do not get what we believe to be our due". Injustice is first in our everyday experience of moral sentiments, and it surpasses justice by far in its intensity and hold on our attention. We understand justice through our feeling for injustice, not the other way round. While justice and injustice may be two sides of the same coin, it is injustice according to this view that is the primary phenomenon. Shklar insists that to understand justice we must explore our sense of – not our beliefs about – injustice. We must examine the sources of our feelings of moral outrage and indignation.

Shklar wants to give priority to the experience of injustice, and states that almost all of our theories of justice fail to give injustice its due. By treating injustice as the mere absence or negation of justice, rather than "as an independent phenomenon in its own right", these theories obscure "the full, complex, and enduring character of injustice as a social phenomenon" (Shklar 1990, p. 9). Moreover, by treating injustice as a mere negation of justice, we are led, she argues, to silence a large portion of the complaints made by individuals who think themselves victims of injustice. For victims of injustice raise a much broader range of complaints than mere departure from recognized standards and principles embodied in the "normal model" of justice.

[3] Two slightly different translations read: "Justice is the set and constant purpose which gives to every man his due"; and "Justice is the constant and perpetual desire to give to each one that to which he is entitled".
[4] The Roman author, orator and politician Marcus Tullius Cicero (106 BCE – 43 BCE) in *De Natura Deorum* [*On the Nature of the Gods*] had earlier used the phrase "*Iustitia suum cuique distribuit*" ["Justice renders to everyone his due"]. But the *Institutes of Justinian* is where it is first codified as a precept of Roman Law.

The "normal model" of justice portrays justice as a body of rules and basic principles governing the distribution of benefits and burdens within a community, and it demands the establishment of effective and impartial *institutions* to guarantee the enforcement of these *basic rules and principles* (as in Rawls 1971). Injustice, according to the normal model, occurs whenever we depart from any of these norms (Shklar 1990, p. 17; Yack 1991, pp. 1335-6). Shklar asserts that by treating injustice as a departure from the basic norms of justice – as embodied in the normal model – we also fail to distinguish between two concepts of injustice: "active injustice" and "passive injustice".

"Active injustice" involves action that departs from or fails to meet the specific requirements of the rules of justice. "Passive injustice", by contrast, involves *inaction* – a failure to "prevent or oppose wrong" when we have the power and occasion to do so. As public officials, we are guilty of passive injustice when we evade responsibility for the disasters we could have foreseen or prevented. The normal model of justice obscures this passive sense of injustice because it suggests that until a standard of justice has been violated, no injustice has occurred.

Like Shklar, Elizabeth Wolgast (1987) in her book, *The Grammar of Justice*, claims that we derive our sense of justice not directly from ideals but contextually and incrementally as we respond to instances of perceived injustice. Injustice rather than justice is the primary concept, and we come to an understanding of what is just by responding to occurrences of injustice. Injustice thus provides an indirect route, a *via negativa*, to identifying the content of justice. Start with injustice, they both argue, if you want to understand justice.

Logically, however, justice still has priority over injustice in Wolgast's view (Wolgast 1987, p. 132, n11). She still treats injustice as nothing but the absence or violation of justice, and recommends that we start with the negation, injustice, in order to identify its positive counterpart, justice, whose absence leads us to get so upset. However, she believes there must be, at least in the imagination, a just order of things that is disturbed by the acts that we call unjust. For her, putting injustice first is chiefly a means of thinking more clearly about justice (Yack 1999, p. 1107).

Shklar does not view injustice as the negation of something positive, viz. justice. She characterizes injustice as the *primary* phenomenon and discounts the evidence of linguistic usage for the word 'injustice', whose actual meaning is 'not just'.[5] Most languages simply affix a negating prefix to the word for injustice. But linguistic usage can often be misleading, and it may be in this case too. It could be that the concept with the *negative* prefix, injustice, is primary and its *positive* counterpart, justice, represents the negation. After all, some positive values do take the form of a negation of something negative. For example, health – a positive value – is often understood as a negation of

[5] The word *injustice* comes from the Latin *in-*, meaning "not", + *justus*, meaning "just".

illness – a negative value. So health might well be defined as the absence of illness, rather than illness as the absence of health (Yack 1999, p. 1108).

3.1. Misfortune versus injustice

Instead of the customary question, 'What is justice?', the central question (and opening sentence) of Shklar's (1990) book is "When is a disaster a misfortune and when is it an injustice?" (Ibid., p. 1). Her answer is that there is no "stable and rigid distinction between the unjust and the unfortunate" (Ibid., p. 9). We need to make this distinction in order to separate naturally caused and unavoidable suffering from the suffering for which we hold other people responsible. As Nussbaum (1990) explains, many cases of human suffering for which we seek to assign blame are due to misfortune and cannot be imputed to any human agency. On the other hand, many disasters that look like simple misfortune turn out to contain elements of human injustice, especially of the sort that Shklar calls "passive injustice" – i.e., negligence, a culpable refusal to get involved, or a blameworthy lack of foresight.

If the focus is on "active injustice", we have a fairly straightforward way of distinguishing injustice from misfortune. According to Nussbaum (1990, p. 33), "a necessary, and perhaps a sufficient, condition of an event being an [active] injustice rather than a misfortune [is] that both (*a*) the event damages the interests of some person or persons, and (*b*) the event is caused by some blameworthy action of a responsible agent".

However, once the focus shifts to what Shklar calls "passive injustice", the task becomes more difficult. An earthquake or a flood or Covid-19 is a natural disaster and a misfortune for those who suffer from it. But it is also an injustice for its victims when their suffering could have been prevented or minimized through appropriate and timely action by public officials. Our efforts to distinguish between misfortune and injustice hinge on our knowledge about the effective means to prevent suffering. We can then state with confidence what we have a right to expect public officials to do in order to prevent or minimize the human suffering caused by such natural disasters. Officials who violate this standard can then be held to account. (Yack 1991, pp. 1340-1)

In keeping with her view that there is no "stable" distinction between the unjust and the unfortunate, Shklar (1990) maintains that the line between misfortune and injustice is changeable over time. Depending on the technological and institutional development of a society, what was simply a misfortune a hundred years ago can turn into an injustice when the response to it today is possible but inadequate, or when the disaster could have been prevented in the first place.

3.2. Covid-19: misfortune or injustice?

In the Covid-19 crisis, misfortune has turned into injustice, as inaction has made governments passively unjust. As noted above, the line between "natural" and "human-

made" crises is difficult to draw. A natural disaster such as the Covid crisis is not simply natural – an external event that has befallen us. Humans may not have created the virus but the way that societies react to its impact moves it from the territory of misfortune into that of justice.

The injustices identified in the Covid crisis are not always the result of active measures. They often follow from complacency, unpreparedness, and neglect – and are frequently aided by political ideologies that foster such inaction. They result from "passive injustice" – a failure to act by governments that does not conform with our expectations to be sheltered from disaster, or to be aided once it strikes. In the Covid crisis, such passive injustices can be identified everywhere. They begin with downplaying the dangers of SARS-CoV-2 or even sometimes flatly denying its existence. They continue with a slow response to the outbreak as well as an inept execution of life-saving measures (Bajohr 2020).

The concept of passive injustice gives us a gauge to assess how the Covid health crisis has been handled, including its secondary consequences – such as people being forced to expose themselves to danger lest they lose their job or livelihood (see Anand 2021). We are faced with a passive injustice when nothing is done where something could be done. Even at the highest level, the institutions of government and society can be appraised through the concept of passive injustice. If a country can institute universal health care for its citizens but fails to do so, a passive injustice is perpetrated that goes to the heart of the society.

4. Defining health justice

4.1. What's in a definition?

What is the use of defining justice or health justice? Sadurski (1985) argues that a definition of justice should be the product of *reflections* about justice, rather than a starting point. In the case of an evaluative or prescriptive concept like justice or health justice, it is difficult to draw a distinction between defining and advocating. Any definition clearly presupposes certain ethical values, and those values should be defended rather than contained in an arbitrary definition.

Sadurski goes on to make a distinction between the 'concept' and 'conception' of justice. The concept of justice merely informs us what justice is about, delineating its scope of discourse. The conception of justice is a product of moral enquiry. The question 'What is health justice?' might be understood as a question about a concept or a conception, a word or an ideal, a definition or an ethical principle. As he puts it, a concept identifies the *field* of moral enquiry whereas a conception attempts to furnish it with moral *principles* –

such as "justice is treating equals equally and unequals unequally" (Aristotle). It is the distinction between posing a moral issue and trying to answer it.

One way to capture the meaning of a moral concept is to record what people mean when they make statements about it (see Section 5 'Conventionalism or What the People Think'). Thus, justice could be defined to mean whatever people mean by 'justice'. But such a Humpty Dumpty approach to the meaning of words does not get us very far.[6] The general public's use of the word, and the literature on justice, shows that there is a huge variety of meanings of justice (see Section 6). A search for their common denominator is likely to be useless – or end up at such high a level of generality that discussion about justice is reduced to banalities. If we resort to the actual usages of an ethical concept, we can neither shape the concept nor make it more precise.

At the other extreme of actual usage is the imposition of an arbitrary definition. All definitions of moral concepts are to some extent arbitrary, but this should not lead us into using well-worn expressions in a completely different way. Existing ways of understanding the concept do impose some constraint on the freedom to craft a definition, especially where high emotions may be attached to certain customary uses of the concept – as, for example, in Shklar's understanding of injustice (Section 3). If the meaning of an ethical concept strays too far from its usual meaning, an epigrammatic definition built on a set of moral principles may lose some of its persuasive power. Moral issues cannot simply be resolved by a definitional fiat.

4.2. An ostensive definition

A capacious concept such as health justice can be described by examples, or it can be characterized by a terse definition. The former procedure is quite standard when we learn certain basic words such as 'green' or 'slab'. An *ostensive* definition conveys the meaning of a word by pointing to examples of things to which the word applies; thus 'green' is the colour of grass.

As Sen (2004b) comments in his Foreword to Paul Farmer's *Pathologies of Power*, the great philosopher of language Ludwig Wittgenstein had discussed the idea of ostensive definition as follows:

"An important part of the training will consist in the teacher's pointing to the objects, directing … attention to them, and at the same time uttering a word; for instance, the word 'slab' as he points to that shape. … This ostensible teaching of words can be said to establish an association between the word and the thing" (Wittgenstein 1958, p. 4).

[6] Humpty Dumpty believes that words mean whatever he chooses them to mean. "When *I* use a word," Humpty Dumpty said [to Alice], in rather a scornful tone, "it means just what I choose it to mean." [Lewis Carroll, *Through the Looking-Glass*, 1871.]

Although not as primitive as 'green' or 'slab', terms like health justice and injustice can also be helpfully communicated through examples.

We could, of course, try to explain a complex concept like health justice in other ways – by proposing a precise and comprehensive definition through use of other words. That indeed is the procedure often used in the social sciences. And yet, as Sen (Ibid., p. xiv) adds, "we know from experience, this is sometimes highly misleading, since the capacious content of a social concept or its diverse manifestations may often be lost or diminished through the manoeuvre of trying to define it in sharply delineated terms".

Attempts at defining the wide-ranging concept of health justice – or its negation, health injustice – exactly and comprehensively by other words is likely to be inadequate. For this reason, among others, the alternative procedure, by exemplification, has many advantages in practical discourse and policy. An epigrammatic definition, which many public health experts seek, often cannot, according to Sen, "escape being misleadingly exact; it can be precise but precisely inaccurate". A rich concept "calls for a characterization that preserves those shady edges, rather than being drowned in the pretense that there is a formulaic and sharp delineation waiting to be unearthed that will exactly separate out all the sheep from all the goats" (Ibid., p. xiv).

In examining the wide-ranging concept of health justice in this paper, we will attempt to identify, classify, and contrast examples of its different faces – such as active and passive, procedural and substantive, comparative and absolute, to mention just a few.

5. Conventionalism or what the people think

In the earlier (Section 3) discussion of injustice, Shklar directed us to place people's expressed views and sense of injustice firmly at centre stage. The approach of basing moral righteousness on public opinion and common beliefs is related to the idea of conventionalism. Conventionalists argue that issues of justice should be resolved by appeal to existing beliefs and social norms about morality and justice, rather than by some ideal theory of justice – as embodied, for example, in the "normal model" (see Section 3).

In a well-known article with the subtitle "What the People Think", Miller (1992) reviews the empirical literature on people's beliefs about justice and the expression of those beliefs in practice. He contrasts it with the growing theoretical work on justice by philosophers and political theorists which, he states, rarely acknowledges the empirical studies of justice – even though most of them "would claim in one way or another to incorporate and systematize existing beliefs about justice in their theoretical constructions" (Ibid., p. 556).

A conventionalist view of justice is offered by Michael Walzer's (1983) book *Spheres of Justice*, where he argues that every social good – such as health care or education – has an appropriate criterion of distribution which is related to how that good is understood by

society. For example, in the UK (and many other societies), health care is understood to concern itself with illness and the restoration of health. This shared understanding of health care entails a distributive criterion, viz. medical *need*. Anyone, therefore, who claims that health care in the UK ought to be distributed in accordance with, say, ability-to-pay has either failed to grasp the nature of the good of health care or falls outside the community which is united and defined by its shared understandings (Barry and Matravers 2011).[7]

Barry (1984, pp. 807-8) has labelled Walzer's position as conventionalism: "the view that justice (what really is just, not what is locally called just) is determined for each society by the shared beliefs of the members of that society about the meanings of the goods that are to be distributed among them. Since these meanings are socially defined, what is just is a matter of convention."

It is doubtful, however, that any society is so homogenous as to subscribe to a single uncontested understanding of the meaning of each of its social goods. Even if it did do so, a Smithian 'impartial spectator' might nonetheless ask whether such a convention-based accord is just. For example, a society marked by gross inequalities based on ascription at birth – such as caste in India – can surely be regarded as unjust on the basis of ideas outside the society. A society may be casteist, racist, sexist and xenophobic; or, alternatively, many commendable things. The philosophical problem of justice is to scrutinize these matters from a normative standpoint. (Barry and Matravers 2011)

The distinction between 'what the people think' and 'ideal justice theory' has also been discussed in a slightly different way by Miller (2017), who differentiates 'conservative' from 'ideal' justice. Conservative justice relies on existing norms and practices, social conventions, and so forth, which are respected under existing law and policy. Ideal justice posits principles of justice based on normative concepts – such as fairness, equality, desert, need, and so on. Thus, ideal justice is seen as proposing principles as they are framed and investigated by philosophers – like Rawls, Sen, and others.

Schramme (2019) makes a similar distinction in terms of what he calls "reconstructing" and "constructing" a theory of justice. A theory may be "reconstructed" from actual social institutions and beliefs empirically identified in a society. Alternatively, it may be "constructed" from certain normative assumptions and mechanisms of theory generation (such as Rawls's 'veil of ignorance' in his 'original position'). Schramme states that Walzer's *Spheres of Justice* is a reconstructed "multispherical" theory of justice, adding that the reconstructive method fails to account for the specific normativity of the concept of justice: "Walzer's interpretative account appears to merely lead to a summary of actual normative beliefs. In other words, the method seems to lead to conservatism or

[7] There is an overlap here with the communitarian perspective on ethics, which tends to justify ethical judgements within the context of a community's traditions and cultural understandings.

conventionalism. Yet a theory of justice cannot simply be justified by claiming that it is the one people believe to be right" (Ibid., p. 41).

There is clearly a distinction between empirical description of 'what the people think' and issues of normative justification. Most philosophers are more concerned with what the people *should* think about justice, rather than in what they *do* think about justice.

6. Conceptions of justice and health justice

More than 250 years ago in *The Theory of Moral Sentiments*, Adam Smith (1759) had noted that justice has several different meanings. The thread running through its various meanings is almost always connected with what is "due" or "owed" to a person. As we noted in Section 2, this goes back to the *Institutes of Justinian* in 6th century CE, where justice is defined as "the constant and perpetual will to render to each his due" (*suum cuique tribuere*). In a major recent work, Scanlon (1998) has investigated issues of justice through a far-reaching examination of "what we owe to each other".

Justice is a wide-ranging concept which can take a number of different forms, depending on the context in which it is being applied. It has been applied in moral, legal and social contexts; in this paper we attempt to apply it in the health context. Health justice is simply justice as it relates to health.

6.1. Conceptions of justice

Many conceptions of justice have been discussed in the literature – from diverse angles and perspectives. It is undoubtedly a multifaceted concept. Different principles or types of justice have been investigated, most of which would seem to apply to the health space. They include:

- Justice as *proportionality* (Aristotle's "treating equals equally and unequals unequally in proportion to their inequality" in *Nicomachean Ethics*)
- Justice as *impartiality* (or justice as *unbiasedness*)
- Rawls's justice as *fairness*, or justice as *equity* [8]
- Justice as *equality* – which is distinct from justice as *equity*
- Justice as meeting *needs* – which is distinct from "justice as equality"

[8] As Sen (2009) explains: "In the Rawlsian theory of 'justice as fairness', the idea of fairness relates to *persons* (how to be fair [or 'equitable'] between them) whereas the Rawlsian principles of justice apply to the choice over *institutions* (how to identify just institutions)" (Ibid., p. 72, emphasis in original). In French there is no distinct word for 'fairness', so in French 'justice as fairness' is translated as 'la justice comme *équité*' or 'justice as equity'.

- Justice as *sufficiency* – which is distinct from "justice as equity" or "justice as equality"
- Justice as *desert* – which is distinct from "justice as equity" or "justice as meeting needs"
- Justice as *moral righteousness* ("*Yi*" in Confucian philosophy)
- Justice as *niti* or *nyaya* (Sen's institutional versus comprehensive justice in early Sanskrit literature on ethics and jurisprudence)

Coming back to the Justinian definition of justice – i.e., "justice is the constant and perpetual will to render to each his due" – the above conceptions of justice have quite different implications of what is "due" to a person. The "constant and perpetual will" part of Justinian's definition is about the impartial and consistent application of *procedures*, such as "treating equals equally and unequals unequally". The parties that dispense what is "due" to a person or to a group of people could be national or international institutions, public officials, governments, or the state – or even private companies or individuals in the case of compensatory or reparative justice.

6.2. Varieties of justice

Different principles of justice will be evoked in determining what is "due" or "owed" to a person. The theory of justice that is typically investigated by philosophers is *distributive* justice (e.g., Rawls 1971, Cohen 1989, Parfit 1997, Dworkin 2000, Sen 2009, inter alia). Section 10 of this paper examines three competing approaches to distributive justice in some detail – equality, priority, and sufficiency. But there are other varieties of justice such as *compensatory* (or *corrective* or *reparative*) justice. These typically involve correcting harm that has been done to a person or persons – through deliberate ill-treatment, discrimination, bias, neglect, and so on.

Other varieties include *substantive* justice and *process fairness* (or *procedural justice*), which are discussed and contrasted in Section 8. Substantive justice is concerned with justice of the *final outcomes*, and process fairness with justice of the *processes* involved in arriving at the final outcomes. In his book, Sen (2009) evaluates justice of states of affairs in the broader terms that include *both* processes and final outcomes – in what he describes as "comprehensive outcomes".[9]

There is also an important distinction to be made between *comparative* and *non-comparative* justice (discussed more fully in Section 9). Comparative justice is concerned with comparing what one person is due with what others are getting. Thus, justice as equality (or justice as equity) is a comparative notion of justice. But a non-comparative

[9] Sen (1997) first used this concept to distinguish a person's preferences over final or "culmination outcomes" from her preferences over "comprehensive outcomes" (which include the choice process). Sen's (2009) account of *nyaya* (as contrasted with *niti*) is concerned exactly with such "comprehensive outcomes".

(or absolute) approach to justice is concerned with what one person is due simply on account of the relevant facts about *that* particular person – no comparison with any others is involved. Thus, justice as meeting a person's needs, or justice as sufficiency, are examples of non-comparative justice.[10]

In legal and social contexts, other types of justice are also investigated – e.g., compensatory and retributive justice (where punishment is involved) in the legal context, and relational and interactional justice in the social context.[11] However, these types of justice lie outside the scope of this paper, even though the latter two might have some relevance in the health context.

Distributive justice is concerned with the nature of claims that arise from distinct distributive principles. The relevant criterion for distribution may be need, desert, or entitlement on grounds of equality or equity. Egalitarian variants of justice include luck egalitarianism, i.e., the neutralization of the effects of bad 'brute' luck – such as severe disabilities or genetic, physical, or mental birth defects. Non-egalitarian variants include *priority* or *sufficiency*, which permit inequalities but assign priority to the worse or worst off, or aim for a *minimum threshold* for everyone – e.g., in health care or health.

There are many types of health justice that are *non-comparative*. If we think of an injustice that affects a person's or persons' health adversely, and is caused by an action or inaction by a responsible agent, then claims of corrective (or reparative or retributive) justice can arise. Corrective justice is concerned with compensating individuals for health harms or other wrongs inflicted on them. The compensation or reparation will be due from the authority responsible – which could be the state, pharmaceutical companies, private corporations, or individuals.

Examples of non-comparative injustice that have involved health harms include the following. Failure to ensure occupational workplace safety has sometimes resulted in industrial accidents and loss of life. Industrial discharges have polluted drinking water and resulted in illnesses and death. Occupational hazards such as exposure to asbestos has caused mesothelioma. Lack of adequate testing of a drug has led to deaths – e.g., thalidomide in the 1950s and 1960s led to thalidomide babies who were deformed or with serious birth defects, and were too damaged to survive. Faulty machinery has led to death, e.g., the MCAS system in the Boeing 737 MAX crashes. Negligent or drink driving continues to cause road accidents and deaths. During the Covid-19 pandemic, failure to supply oxygen, drugs, therapeutics, PPE in hospitals in India and several other countries has led to innumerable deaths. These are all examples not of distributive but of non-comparative health injustices.

[10] Justice as desert (e.g., what is "due" as reward for a person's effort or talent) is generally non-comparative, but sometimes the claim for desert can arise from comparison with what other people are getting.

[11] Prominent advocates of relational and interactional equality are Anderson (1999) and Scanlon (2018).

In short, there are many types of health justice and injustice, both distributive and non-distributive. Some distributive injustices are comparative whereas others are non-comparative (e.g., sufficiency). Most non-distributive injustices are not comparative. The subcategory of distributive and comparative injustices, one example of which is health inequity (see definition in Section 11), forms a strict subset of the totality of health injustices.

6.3. The currency of health justice

The term "currency" was coined in relation to egalitarian justice by G. A. Cohen (1989), where he discussed different types of *equalisandum* (i.e., that which is to be equalized, or the object of equalization). More generally now, "currency" is used to denote the object or variable – e.g., primary goods, welfare, capabilities – in terms of which advantage and deprivation are assessed in any theory of justice.

The currency of health justice is the feature of people's health that is regarded as fundamental in assessing advantage or deprivation in the space of health. In this space, health capabilities are seen by many as the relevant currency, rather than health care or health status. The most basic health capabilities are the capability to avoid premature mortality, the capability to escape preventable morbidity, and the capability to be free from hunger and undernourishment (Sen 1980, 1992). The capability perspective, as we will discuss in Section 7, is especially powerful in understanding the nature of deprivation caused by ill-health and disability.

Health resources, in contrast, are the *means* to attain health capabilities, which themselves are the *ends* (or "culmination outcomes" as discussed in Section 8). Health resources include the various determinants of health: health coverage and access to health care and treatment by medical professionals; social, material, financial, and human resources; public health measures (nutrition, sanitation, clean water supply, immunization); control of epidemiological and environmental factors; etc. These resources constitute the *distribuendum* (i.e., that which is to be distributed) in distributive health justice.

7. Contrasting Rawls and Sen on justice in health

In his book *The Idea of Justice*, Sen (2009) proposes a different approach to justice from the mainstream theories of justice, including John Rawls's *A Theory of Justice* (1971), which are basically 'contractarian' and comprise what we earlier called the "normal model" of justice in Section 3. Sen's book presents arguments for what is *required* from a theory of justice, including his proposals to address these requirements. His approach is a clear departure from the normal model and does not commit us to an inflexible concept of justice. Here I will attempt to contrast the most influential contractarian theory of justice

of our time, that of Rawls (1971), with Sen's *The Idea of Justice* – in terms of their respective implications for justice in health.

Although there are many contrasts between Rawls and Sen in addressing justice and injustice in health, I will limit the comparison to five important differences between them.

(i) The Rawlsian project of characterizing the *perfectly just* society, versus Sen's *comparative* approach to advancing justice – which enables binary comparison between less than ideal or perfect situations.

(ii) Rawls's focus on *institutions* in characterizing a just society for its basic structure, versus Sen's approach on the lives that people actually lead – 'realizations' as he calls them – including the *processes* that lead to the outcomes.

(iii) Rawls's focus on 'primary goods' as the means to the substantive freedoms that people can enjoy, versus Sen's reliance on people's 'capabilities'.

(iv) The nature of *impartiality* involved in the assessment of justice – 'closed' in Rawls's case in his 'original position', and 'open' in Sen's case of the impartial observer with, as it were, a 'view from everywhere'.

(v) Rawls's consideration of justice being limited to the sovereign or nation state (in a 'fair system of cooperation'), versus Sen's universalist approach that permits assessment of *global* justice.

Each of these five contrasts has implications for the judgements about justice that *can* and *cannot* be made in relation to people's *health*. The last of them – matters to do with global justice – seem to lie clearly outside the scope of Rawls's framework, even if this were extended to include his later work *The Law of Peoples* (1999), which concerns just relations *between* sovereign states. By contrast, through a process of 'public reasoning' and invoking the Smithian 'impartial spectator', Sen is able to comment on global justice: for example, the injustice involved in the non-availability of vaccines or cheap (generic) drugs for poor people suffering from many life-threatening conditions in developing countries such as Covid-19 (or malaria, TB and AIDS); the absence of medical facilities in many regions in Asia, Africa and elsewhere; the lack of universal health coverage in most countries in the world; or the fact of life expectancy at birth in some countries being a whole generation or more (30 years) less than in other countries.

I would like to illustrate some other contrasts between Rawlsian and Senian theory of justice by considering the health of people *within* a country or nation state. Rawls assumes that participants in his 'original position' are healthy and able-bodied, and states:

"We assume that persons as citizens have all the capacities that enable them to be cooperating members of society … [W]e do not mean to say, of course, that no one ever suffers from illness and accident; such *misfortunes* are to be expected in the ordinary

course of life, and provision for these contingencies must be made" (*Political Liberalism*, 1993, p. 272, italics added).

Note the view expressed here of ill-health as a "misfortune", rather than something that could be caused, in part at least, by a less-than-perfect basic structure of society, including its social and economic institutions, and by the government's and people's less-than-ideal behaviour.

Since health does not enjoy a special status in Rawls's theory, *all* socio-economic inequalities in health must be regarded as *just* provided that the basic structure of society is *just*. Rawls's goal is not to achieve a specific pattern of health outcomes, but a *just* basic structure of society. If the basic structure is just, then all outcomes – including all health outcomes – that these institutions produce must be considered just.[12] This judgement reflects both the transcendental and the institutional focus of Rawls's theory – in contrast with the comparative and realization-based perspective of Sen.

Another important contrast is judging advantage not in terms of Rawlsian primary goods (i.e., resources such as income and wealth), but in terms of capabilities. The capability perspective is particularly powerful in understanding and analyzing the nature of deprivation in the health space – for example, that caused by ill-health and disability. In his book, Sen (2009, pp. 258-60) discusses the global problem of disability – with more than 600 million disabled people (or one-tenth of the world's population) of which 400 million live in developing countries and are often the poorest in terms of income.[13] By virtue of their disability, they suffer an 'earning handicap'. But their *need* for income is greater than that of able-bodied people in order to try to live normal lives and alleviate their handicaps. This difficulty in *converting* income or primary goods into good living and functioning – a 'conversion handicap' – reinforces and greatly magnifies the 'earning handicap'. The serious deprivation resulting from disability can be captured *directly* through the capability perspective – in contrast to an assessment of disadvantage based on income or primary goods, which ignores the plight of disabled people.

[12] As Anand and Peter (2000) argue, a just basic structure of society could nonetheless produce inequalities in health that are considered unjust. See also the discussion in Daniels (2008, 2015), Preda and Voigt (2015a, b), Kelleher (2015), and Sreenivasan (2014, 2015, 2020).

[13] Sen (2009, p. 258) attributed these estimates of disability to the World Bank. But the current (2021) World Bank numbers for disability are much higher at 1.0 billion or 15% of the world's population, with 80% (or 800 million) living in developing countries (https://www.worldbank.org/en/topic/disability). The WHO numbers are similar (https://www.who.int/news-room/fact-sheets/detail/disability-and-health). The global human rights movement '*WeThe15*' puts the figure at 1.2 billion people with disabilities.

8. Process fairness versus substantive justice

An important distinction to be made concerns justice of the *processes* or *procedures* used in arriving at final outcomes and justice of the final or 'substantive' outcomes themselves. For some philosophers, the justice of a process is assessed solely by the justice of the consequences or outcomes that it tends to produce when applied. However, the process itself clearly has *independent* value in whether or not it treats the people to whom it is applied fairly. Substantive justice refers to fairness of the end-state itself, for example, the distribution of the final outcomes in terms of health or some other currency. A critical instance of the distinction in rectifying a health inequality is discussed in Section 8.1 below.

In judging the justice of states of affairs, Sen (2009, pp. 215-21) focuses on what he calls 'realizations' (in contrast to institutions and rules as in Rawls). By realizations is meant the lives that people are able to lead, which depend on their actual behaviour (in contrast to ideal behaviour as in Rawls), their social interactions, and other significant determinants. Sen maintains that a full characterization of 'realizations' should include the *processes* through which the eventual states of affairs emerge.

The distinction turns on the difference between a 'culmination outcome' and a 'comprehensive outcome'. A comprehensive outcome incorporates the processes of choice, the actions and policies undertaken, the agencies involved, and so on – *together with* the final or 'culmination' outcome that is detached from such processes, actions, and agencies. Justice is concerned with the evaluation of states of affairs seen in the broader terms of comprehensive outcomes – which Sen refers to as 'social realizations'.

In the area of health justice, we can similarly distinguish between culmination outcomes and comprehensive outcomes. In assessing health justice, we should be concerned not only with final health outcomes but also with the *processes* that lead to the end-states. In Anand (2021, Table 1) I had identified the processes (stages) through which various health outcomes or end-states, including recovery or death, culminate from Covid-19. Hence that paper may be regarded as presenting a framework for what we can call 'health realizations' – which are a subset of Sen's 'social realizations'. Health justice, then, should be concerned with evaluating 'health realizations' and not merely health end-states.

8.1. Equalizing the life expectancy of women and men

The importance of the distinction between 'process fairness' and 'substantive justice' is well illustrated in a commentary by Sen (2004a, pp. 29-30) on equalizing the life expectancy of women and men. It is well-known that women have a biological and

genetic advantage compared to men in longevity.[14] Given equal treatment in health care and nutrition, women outlive men by several years, up to 10 years in some countries. The strict health egalitarian, for whom equality trumps other aspects of justice, will want to close this gender gap in life expectancy.

However, different types of reason can be adduced for *not* seeking equality of life expectancy between men and women. Levelling-down women's life expectancy so that it becomes equal to men's lower life expectancy is subject to Parfit's "levelling-down objection" against equality as an end in itself, which I discuss in Section 10.

Sen (2004a, pp. 29-30) examines such levelling-down from the viewpoint of process fairness or process equality, through reference to the "fair innings argument" of Williams (1997, 1998). As a putative principle of health justice, the fair innings argument (FIA) is briefly reviewed and evaluated below.

According to Williams (1997, p. 117), the concept of a "fair innings" is based on the view that everyone is "entitled to some 'normal' span of health (usually expressed in life years, e.g. 'three score years and ten') and anyone failing to achieve this has been cheated, whilst anyone getting more than this is 'living on borrowed time'." A later statement of FIA by Tsuchiya and Williams (2005, p. 278) states that "when people reach a certain age they have had their fair innings and nothing more should be done to prolong their lives." A "more moderate form" of FIA still upholds that their "moral claim on resources is lower" after they have had their fair innings.

Williams (1998, p. 327) notes the fact that the differences in prospects of a fair innings can be "very large between social classes" and that "the difference in life expectancy at birth *between men and women* in the United Kingdom is even greater than that between social classes!". He concludes: "We males are not getting a fair innings!".

In a sharp riposte Sen (2004a, p. 30) comments: "The difficult issues arise after this has been acknowledged. What should we then do? If, as the fair innings approach presumes, this understanding should guide the allocation of health care, then there has to be inequality in health care, in favour of men, to redress the balance. Do we really want such inequality in care? Is there nothing in the perspective of process equality to resist that conclusion, which would militate against providing care on the basis of the gender of the person for an identical ailment suffered by a woman and a man?".

[14] The reasons are to do with differences in biology and genes – sex hormones and chromosomes. For example, testosterone increases levels of LDL (bad cholesterol) and decreases HDL (good cholesterol), whereas estrogen has beneficial effects on cardiovascular health by lowering LDL and increasing HDL. There are also other detrimental effects of testosterone (e.g., association with risky behaviours) and beneficial effects of estrogen (e.g., as an antioxidant). Chromosomal differences, XX for women and XY for men, may also affect relative mortality rates – because an abnormal gene on one X chromosome for women can use the normal gene on the other X chromosome, but men cannot rely on an alternative chromosome if a gene on one of the chromosomes is defective. Currently, modern medicine does not have the technology to compensate for men's biological and genetic disadvantage.

He makes a similar comment about the conclusion reached by Culyer and Wagstaff (1993) in their celebrated paper "Equity and Equality in Health and Health Care". Culyer and Wagstaff (Ibid., p. 431) state that "… equality of health should be the dominant principle and that equity in health care should therefore entail distributing care in such a way as to get as close as is feasible to an equal distribution of health". Sen (Ibid., p. 30) retorts: "But should we really? A gender-check, followed by giving preference to male patients, and other such explicit discriminations 'to get as close as is feasible to an equal distribution of health' cannot but lack some quality that we would tend to associate with the process of health equity."

Process fairness in these cases would seem to override the strict health egalitarian's substantive justice demand for equality in longevity between women and men. In fact, the observation of *equality* of female and male life expectancy at birth in a country would be strong evidence of a health *injustice*.

9. Comparative versus non-comparative justice

The distinction between comparative and non-comparative justice goes back to Feinberg (1974) who contrasted the two concepts as follows:

"In all cases, of course, justice consists in giving a person his due, but in some cases one's due is determined independently of that of other people, while in other cases, a person's due is determinable *only* by reference to his relations to other persons. I shall refer to contexts, criteria, and principles of the former kind as *noncomparative*, and those of the latter sort as *comparative*" (Ibid., p. 298, emphasis in original).

Justice thus takes a comparative form when the determination of what is due to a person depends on what might also be due to other people. It takes a non-comparative form when we can determine what is due to a person simply by knowing the relevant facts about that particular person.

Theories of justice can be categorized according to whether they are comparative, non-comparative, or both. Principles of equality – principles that require equal distribution of a resource – are plainly comparative in form, since what is due to each person is the same as what others are getting. Similarly, the widely-used concept of 'health inequity' is also comparative, because it involves the identification of health *differences* between people that are "avoidable and unfair" (see Section 11).

In the case of principles of sufficiency, the determination of what is due to a person is non-comparative. A person may be entitled to an absolute amount of some benefit – e.g., 'a minimum wage' – without reference to anyone else. Prioritarian principles such as Rawls's Difference Principle or a "weighted priority" principle require the identification of beneficiaries comparatively (who is the worst off or who are the worse off). However, the

distribution of the absolute amount of benefit is non-comparative in the Rawlsian case, but it is comparative in the weighted priority case (see Section 10).

The sufficiency principle is straightforwardly non-comparative: it holds that each person has 'enough' in the currency in question. For example, everyone should have their basic needs met or have a specified set of basic health capabilities (Nussbaum 2000, p. 71). Once the condition of badly-off persons has risen above what is minimally required, their claims according to the sufficiency principle are exhausted. Unlike this, however, the claims of the worst off under Rawls's Difference Principle remain in force – as long as they can do better still. In that sense, prioritarianism is regarded as a comparative principle.

Of the varieties of justice mentioned in Section 6.2, compensatory, restorative and retributive justice are evidently non-comparative principles. So are most 'needs' or 'desert' based claims of justice. Process fairness generally involves comparison across people and hence is comparative – e.g., equal treatment of women and men, of different races, of different caste groups, and so on. Distributive justice, as an aspect of substantive justice, also generally involves comparative assessment; but some types of distributive justice – e.g., the sufficiency criterion – do not. Health equality and health equity, however, are always comparative concepts. Equality is obviously a comparative concept as is health equity, which is concerned with health differences between people. In summary, health justice encompasses a wide variety of comparative as well as non-comparative faces of justice.

10. Equality, priority, and sufficiency

In this section I discuss in turn three different principles of distributive justice as they apply to health: equality, priority, and sufficiency.

10.1. Equality

Most theories of justice demand equality in some form – whether it is in terms of equal treatment, equal respect, equal status, equal liberty, equal income, etc. They all rest on the widely-accepted idea of basic moral equality – that everyone is equal in fundamental worth or moral status. Equality of some sort is universally seen as a central component of justice. Here I restrict discussion of equality to the type of justice widely examined by both philosophers and economists, viz. *distributive justice*. In other types of justice, equality might even be constitutive – as in process fairness or relational justice.

In a pioneering essay on distributive justice four decades ago, Sen (1980) posed and investigated the question "Equality of What?", to which several competing answers have subsequently been offered. The "what" or "currency" that Sen proposed was human capability to function – in sharp contrast to primary goods, income and wealth, resources,

welfare, or opportunity for welfare (as in Rawls 1971, Cohen 1989, Dworkin 2000, Arneson 2013, inter alia). I have elsewhere (Anand 2004) commented on the critical relevance of the capability perspective in the health space.[15]

Egalitarianism in distributive justice has strong intuitive appeal in the space of health and well-being, because being worse off than others through no fault of one's own seems unjust. Severe illness from Covid-19 suffered by some groups through risk factors they cannot avoid is an obvious example in this respect (see Anand 2021). There are large inequalities between groups at each stage in the progression of Covid-19 – in susceptibility, exposure, behaviour, vulnerability, treatment, and recovery or death.[16] Procedural and substantive health justice both demand protection from and treatment for undeserved health outcomes.[17]

The 'Principle of Equality' posited by Parfit (1997, p. 204) states that: "It is *in itself* bad if some people are worse off than others".[18] As such, equality is valued *intrinsically* and not for some other reason. A central objection to pursuing equality for its own sake is that equality can be achieved by *reducing* the health (well-being) of the better off down to the level of the worst off. Parfit calls this the "levelling-down objection".[19] The strict (or "pure" according to Parfit) egalitarian would prefer a situation in which the worst off's health is not made better and everyone else is made *less* healthy. If equality per se is the aim, what reason have we to reject the (repugnant) conclusion of bringing everyone *down* to the lowest level to achieve equality?

One type of objection to levelling-down concerns the processes through which it might be achieved – see the earlier discussion in Section 8.1. There we considered inequality in life expectancy between women and men, with women typically living several years longer than men. If equality in longevity were the exclusive aim, we could bring this about by giving women less health care and medical attention than men. That, however, "would flagrantly violate a significant requirement of process equity (in particular, treating different persons similarly in matters of life and death)" (Sen 2009, p. 296). Demands of

[15] See also Nussbaum and Sen (1993), Nussbaum (2000), Ruger (2010, 2018) and Venkatapuram (2011).
[16] In Anand (2021) I develop a framework for analyzing the risk factors and health consequences of Covid-19, and discuss particular groups that are at high risk of contracting the disease and suffering its serious health consequences.
[17] Undeserved health outcomes also arise from bad (brute) luck, such as being born with a congenital defect. Luck egalitarians hold that bad *brute* luck raises issues of justice, but not bad *option* luck which is brought about by free choices (for a review see Lippert-Rasmussen 2018). However, so-called "free" choices may be influenced by a person's circumstantial factors. The issues of personal and social responsibility for health are well discussed by Wikler (2004).
[18] In an accompanying footnote, Parfit adds "through no fault or choice of theirs".
[19] The expression "levelling down" was used earlier by Sen (1992, p. 93) where he referred to "attainment equality" being "unfeasible or inefficient (involving the 'levelling down' of all to the condition of the lowest achiever)". He also stated that "… equality would typically be one consideration among many, and this could be combined with *aggregative* considerations including *efficiency*. These latter influences would work against choosing 'low-level equality'." (Ibid., p. 92, emphasis in original)

process fairness in such cases clearly override the single-minded aim of achieving end-state equality.

The levelling-down objection has been advanced by Parfit (1997) as a reason for rejecting egalitarianism in favour of prioritarianism – which is the view that we should be concerned with improving the condition of the worse and badly off rather than with the *difference* between what some people have and what others have. We consider different versions of the prioritarian principle in the next subsection.

10.2. Priority

Rawls's Difference Principle is perhaps the most famous version of prioritarianism. It assigns a normative priority for the *worst off*, not the worse or badly off. Distributions are evaluated solely by the level of well-being (or relevant currency) of the worst-off person. All that matters is making the position of the worst-off person better – hence the moniker 'maximin' used to describe Rawls's principle.

A strict application of 'maximin' shows that the principle is consistent with virtually *any* level of inequality in the society. As long as the worst-off person has been made even a little better off, those above that level could be made substantially and disproportionately better off – thereby increasing inequality greatly. Alternatively, those above the level of the worst-off person could all be brought *down* to the slightly improved position of the worst-off person – thereby achieving perfect equality in the society.[20] Both these distributions, according to maximin, will be an improvement on the original distribution, because in *both* cases the worst-off person has been made better off. Hence the Difference Principle would seem to have little to do directly with either equality or inequality.

A less extreme form of prioritarianism attaches a positive weight to the well-being (or relevant currency) of *all* persons and not just the worst-off person – a view known as "weighted priority" and attributed to Parfit (1997). This has the immediate effect of preventing Parfit's levelling-down objection. However, the choice of weights has been discussed in the philosophy literature only in *ordinal* form. Thus Parfit (1997, p. 213) states: "We should not give equal weight to equal benefits, whoever receives them. Benefits to the worse off should be given more weight". Arneson (2013, p. 26) comments further: "Prioritarianism holds that the moral value of achieving a benefit for an individual … is greater, the greater the size of the benefit as measured by a well-being scale, and greater, the lower the person's level of well-being". The objective, he states, is to maximize aggregate moral value as specified in such "weighted well-being". But a

[20] Prioritarianism in this form is essentially subject to the "levelling-down objection". For example, if the poorest person in an unequal income distribution is made £1 better off and all those with incomes above that level (assuming their incomes are more than £1 above his original income) are brought *down* to his new (£1 higher) income, then according to maximin the new equal distribution will be an improvement on the original unequal distribution. Equality will have been achieved effectively by "levelling down".

maximization exercise needs to specify the priority weights *cardinally*, not ordinally. In other words, we need to know how much greater "priority", or how much more "weight", should attach to the less well-off compared to the better-off.

In a paper on health equity published two decades ago (reprinted as Anand 2004), I had adopted a welfare-economic approach to assessing the distribution of health outcomes, where both the *levels* (or 'efficiency') and *inequality* of health are explicitly incorporated in a scalar metric of the social (or 'moral') value of the distribution (see also Section 11.1). This metric is constructed using a cardinal system of declining weights on individual levels of well-being (or health). The weights on well-being are determined by a parameter ε (due to Atkinson 1970), the size of which measures the rate of decline of the marginal value of well-being from unit increments in well-being.

The parameter ε is simply the elasticity of the marginal value of well-being and is assumed to be constant throughout its range. It is a measure of the extent of "relative inequality aversion". If ε = 0, there is no decline in the marginal value of well-being and everyone's well-being has exactly the same weight (the 'utilitarian' case). For positive ε, the lower a person's well-being, the higher is the weight on her well-being. As ε increases, the weight on someone who is less well-off increases relative to the weight on someone who is better off. When ε becomes infinitely large (∞), a positive weight is placed only on the *least well-off* person and the weights on everyone else shrink to zero; this corresponds to the Rawlsian 'maximin' case (see Anand and Sen 1995, Anand 2004).

In this formulation, for any given ε, the social (or moral) value of an unequal well-being distribution is reducible to an 'inequality-adjusted average' obtained by what we called '(1-ε)-averaging' (Anand and Sen 1995). A '(1-ε)-average' is an arithmetic average of each individual well-being raised to the power (1-ε), and then taking its 1/(1-ε) root. As ε increases, the following well-known types of '(1-ε)-order average' of the distribution are obtained: for ε = 0, the arithmetic mean; for ε = 1, the geometric mean; for ε = 2, the harmonic mean; and for ε = ∞, the *minimum* level of well-being in the distribution. The larger is ε, the smaller will be the (1-ε)-order average. As the aversion to inequality ε increases, the social value of a given unequal distribution gets smaller after adjusting for inequality (see Anand and Sen 1995, pp. 5-8). The 'cost' of inequality is larger with a greater aversion to inequality ε, which results in a smaller value after adjustment for inequality.

10.3. Sufficiency

In the philosophical literature, the idea of 'sufficiency' as it is contrasted with 'equality' appears to be due to Frankfurt (1987). His discussion is couched in terms of economic (for short, "money") equality versus sufficiency, but other philosophers have cast the difference more widely in terms of currencies such as well-being, capabilities, and quality of life (see, e.g., Wolff 2007, Arneson 2013, Miller 2017).

Frankfurt (1987) is against the idea of equality: "The fundamental error of egalitarianism lies in supposing that it is morally important whether one person has less than another regardless of how much either of them has" (Ibid., p. 34). His argument in favour of sufficiency is: "[What] is important from the point of view of morality is not that everyone should have the *same* but that each should have *enough*. If everyone had enough, it would be of no moral consequence whether some had more than others. I shall refer to this alternative to egalitarianism … as 'the doctrine of sufficiency'." (Ibid., pp. 21-22, emphasis in original)

Frankfurt's first statement in his 'doctrine of sufficiency' about everyone having enough is well understood as the 'principle of sufficiency'. But his second assertion about no moral significance attaching to whether some have more than others if everyone has enough, is questionable. Even when sufficiency is achieved, great inequalities remaining above the sufficiency threshold *can* be of moral consequence. Indeed, egalitarian concerns can arise in tandem with sufficientarian ones, and there is no reason why egalitarianism and sufficientarianism must be seen as mutual alternatives. Economists have long been concerned with the reduction of *both* income inequality *and* income poverty – the economic counterparts of egalitarianism and sufficientarianism.[21]

As a principle of justice, sufficientarianism determines what is "due" to a person on the basis of a given absolute standard, not on the basis of what other people have. The absolute standard is a sufficiency threshold in the relevant currency, and sufficientarianism aims to bring everyone up to this standard ('poverty line' in economics). Frankfurt sees the job of justice as done when absolute deprivation has been addressed. However, other aspects of justice are not ruled out in attempting to implement sufficiency, which can raise simultaneous and additional distributional issues.

Distributive issues are involved in implementing sufficiency when too few resources are available to bring everyone up to the threshold. Should we then maximize the number of people who achieve sufficiency by helping those just below and closest to the threshold (line) get over it, while leaving others where they are below it? Or should we minimize the average shortfall of all those who are below the threshold? Should we seek equality of shortfalls of all those below the threshold?[22] Suppose, at the other extreme, there

[21] Since at least 1970, Atkinson, Sen and other economists have been making the case for the reduction of both inequality and poverty. My own doctoral thesis in 1978, and book, *Inequality and Poverty in Malaysia: Measurement and Decomposition*, is a detailed investigation of the pursuit simultaneously of both these goals. Its technical Appendix E 'Lemmas on Lorenz Dominance' (Anand 1983, pp. 341-5) examines the connection between poverty and inequality, and shows that what I call the 'Redress of Poverty Rule' (viz., 'levelling-up' from the bottom upward) is most "efficient" for the redress of inequality too.

[22] In the measurement of income poverty, these are the tradeoffs that are explicitly addressed – including equality below the poverty line. The original contribution is by Sen (1976) who proposed an index of poverty that incorporates: (i) the headcount ratio *H*, which counts the proportion of people below the poverty line; (ii) the income-gap ratio *I*, which measures the proportionate average income shortfall of the poor from the poverty line; and (iii) inequality below the poverty line, measured by the Gini coefficient *G* of the income distribution among the poor.

happens to be a *surplus* of resources once everyone has 'enough'; how should the surplus be distributed? These questions, too, are matters of justice which will need to be addressed when the sufficiency principle is implemented.

Some critics argue that setting a sufficiency threshold or line is to some extent arbitrary – at least within a sizeable interval. Why then does moving a person just over this line – from barely (a hair) below it to barely (a hair) above it – have great moral significance? Why isn't priority given to those far below the threshold – as it is in versions of prioritarianism where benefits to those further below the line are given higher weight? One way of dealing with the sharp discontinuity at the sufficiency line is to use continuous "priority weighting" for people throughout – below, across, and above the line. As discussed in the previous subsection, this can be achieved through the weighting function implied by the inequality aversion parameter ε, which determines the rate of continuous decline of the weights throughout the range. The size of ε is, of course, a normative question as is the specification of any priority weights, and as is indeed the sufficiency threshold itself. The sufficiency principle does not absolve us from dealing with additional matters of distributive justice.

As the above discussion has indicated, the doctrine of sufficiency cannot be asserted as a complete theory of justice. In the earlier subsections we also noted shortcomings with the free-standing principles of equality and priority. In summary, none of the three principles of equality, priority, or sufficiency can be upheld by themself as a complete theory of distributive justice. There are many aspects and faces of distributive justice, and a plural understanding of distributive health justice is warranted.

11. Health inequality, health inequity, and health justice

In a contribution to the World Health Organization's Health for All policy, Margaret Whitehead (1992) proposed a definition of health equity that has become standard and very widely cited.[23] The term "inequity", she states, refers to differences between groups "which are *unnecessary* and *avoidable*, but in addition are considered *unfair* and *unjust*" (Ibid., p. 431, emphasis in original).[24] On the other hand, the word "inequality" simply

[23] See, for example, Evans et al. (2001), Daniels (2008, 2015), Segall (2010), Venkatapuram (2011), Eyal et al. (2013), Preda and Voigt (2015a, b), Schramme (2019), Sreenivasan (2014, 2020), and innumerable studies on social determinants of health.

[24] I have a semantic quibble with Whitehead's (1992), and Dahlgren and Whitehead's (1991), definition of health inequity. Why do we need to establish that health differences are "*unnecessary* and *avoidable*" before they can be judged "*unfair* and *unjust*"? In Anand and Peter (2000, p. 49) we commented on the redundancy of the first clause in this definition by arguing that "… fairness surely subsumes what is unavoidable and what is 'necessary'. Problems of justice and fairness arise only if a certain outcome could have been otherwise; and if what is necessary is interpreted to mean something other than what is unavoidable, then a judgment on what is necessary must ultimately be made with reference to justice and fairness". For example, the higher life expectancy of women compared to men is "unnecessary and avoidable" – and can be avoided by denying women health care and through other discriminatory practices.

refers to differences in an elementary mathematical sense. Whitehead's definition seeks to answer the question: When is a health inequality a health inequity?

Both health inequity and health inequality are about health differences or comparisons between people, and are therefore a *comparative* justice concept. According to its definition, a health inequity requires a judgement on how one group is doing *relative* to another – whether the health differences between people are unfair or unjust. Health injustice, by contrast, is a much broader concept which includes *both* comparative and non-comparative assessments of *both* procedural and substantive justice (see Sections 8 and 9). Health inequity is restricted only to comparative assessments of substantive justice, and hence forms a proper subset of all health injustices.

An example of non-comparative substantive injustice is health insufficiency because no comparison with other people is involved to gauge injustice. If a group has not reached a threshold level of health, we deem it to have suffered a health injustice. An example of comparative procedural injustice (or process unfairness) is *unequal access* to health care for *different* population groups. Lack of *access* to basic (or to a threshold level of) health care for a person would be an example of non-comparative procedural injustice.

In distinguishing between the concepts of health inequality and health inequity that are widely used, and of health injustice as developed in this paper, Figure 1 below presents a Venn diagram showing the relationship between health inequality, health inequity, and health injustice. The diagram shows the sets that correspond to the three concepts and their respective overlap or intersection. The distinctions that delineate membership in each pair of sets are as follows.

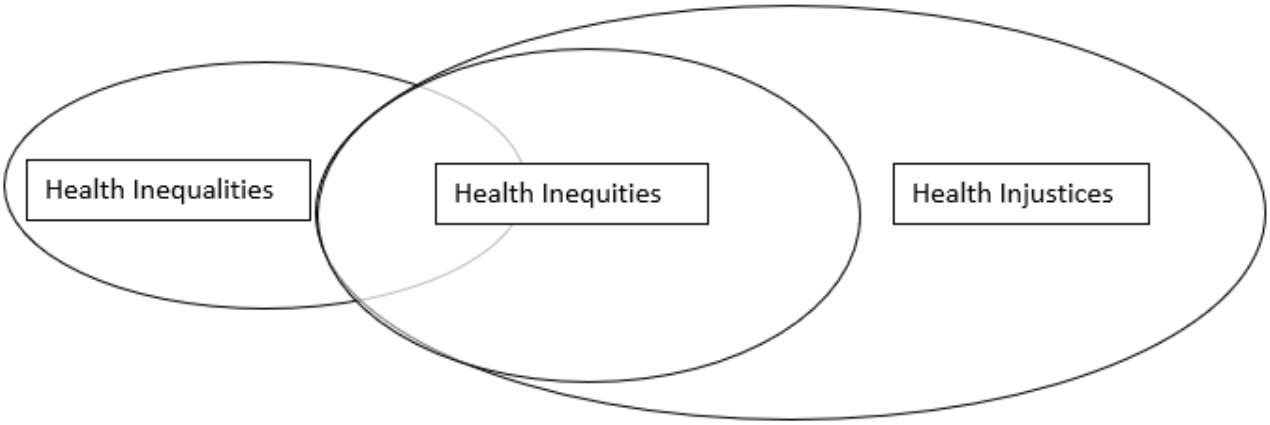
1. Not all health inequalities are health inequities. For example, female life expectancy greater than male life expectancy is a health inequality but not a health inequity, because the inequality is not unfair.
2. Not all health inequities are health inequalities. For example, female life expectancy *equal to* male life expectancy is a health inequity but not a health inequality.[25] (See Section 8.1.)
3. Not all health inequalities are health injustices. Female life expectancy greater than male life expectancy is a health inequality but not a health injustice, because the inequality is not unjust.

But there are reasons of justice and fairness not to do so and to treat women and men equally. We will often need normative judgements to decide whether health inequalities are 'necessary and unavoidable', not merely empirical judgements – *pace* Sreenivasan (2014, 2020). See also Kelleher (2015) and Wolff (2015).

[25] Female life expectancy equal to (or lower than) male life expectancy has been observed in several countries in the past, especially in South Asia and the Middle East, where gender bias against women has been documented. In regard to the definition of 'health inequity' (see previous footnote), the female-male gap being biologically "necessary" did not prevent its elimination in these countries.

4. Not all health injustices are health inequalities. For example, female life expectancy *equal to* male life expectancy is a health injustice but not a health inequality (see Section 8.1). As another example, health insufficiency is a health injustice but not necessarily a health inequality.
5. All health inequities are health injustices. Health inequities form a proper subset of the set of health injustices, which include all comparative and non-comparative, and procedural and substantive, health injustices (such as unequal treatment in medical care, insufficiency, inefficiency, unmet need- or desert-based claims, compensatory and reparative claims, etc.).

Figure 1. The relationship between health inequality, health inequity, and health injustice



6. Not all health injustices are health inequities. For example, a person who has less than the threshold level of health (or health care) suffers a health injustice under the sufficiency principle, but not a health inequity because no comparison with other persons is involved.

In summary, there are many faces of health injustice: comparative and non-comparative, procedural and substantive, compensatory and reparative, active and passive, etc. Health inequity is just *one* face of health injustice: it belongs to the strict subset consisting of comparative and substantive health injustices. Health injustices that are *not* health inequities include all non-comparative and substantive, and all procedural (rather than substantive) comparative and non-comparative, health injustices.

11.1. Health gradients and aggregate health

There is now a large empirical literature examining health differences among population groups within a country ranked by income, wealth, or other socio-economic status (SES) variable, e.g., education. Significant differences in health status between lower and higher ranked groups, labelled 'health gradients' or 'social gradients', have been documented in this literature. As the WHO Commission on Social Determinants of Health (CSDH 2008) puts it: "In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health" (Ibid., Executive Summary, para 1). The CSDH Report seems to endorse the Whitehead (1992) definition of "health inequity" when it upholds: "Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity" (CSDH 2008, Executive Summary, para 2).

Chapter 2 of the CSDH Report goes on to review findings from the empirical data on health and SES indicators in several countries. In its analysis of these data, the Report emphasizes that the relation between socio-economic level and health is "graded": people in the second highest quintile have worse health than those in the highest quintile, and those in the middle have worse health than those above them (Ibid., p. 31). It concludes that: "… the greater the social disadvantage, the worse the health. The steepness of the gradient varies over time and across countries. It is likely, then, that action on the social determinants of health would reduce the social gradient in health" (Ibid., p. 31). The Report also notes "how quickly the magnitude of the social gradient in health can change" (Ibid., pp. 32-3), and that "closing the health gap in a generation … involves a progressive flattening of the health gradient" (Ibid., p. 197).

These health gradients between the lower and higher ranked groups have increased over time in some countries and are larger in some countries than in others.[26] In this sense, the comparisons show that differences in health between SES-ranked groups have increased or are greater in some countries than in others. According to the Whitehead definition these health gradients are health inequities if they are "avoidable" and "unjust", and hence as noted earlier they will also be health injustices.[27]

[26] When several groups are being compared, we can use the slope index of inequality to estimate the gradient of health status across the income- or SES-ranked groups by means of a weighted least squares regression – see Anand et al. (2001, p. 57).

[27] In a provocative article by Preda and Voigt (2015a) entitled "The Social Determinants of Health: Why Should We Care?", the authors argue that while health gradients provide evidence of the social determinants of health, they are not *in themselves* a demonstration of inequity or injustice. Preda and Voigt are critical of what they call the "health equity through social change model" (HESC) and contend that the normative underpinnings of the approach lack a solid philosophical foundation. Their article has spawned more than a dozen Open Peer Commentaries in *The American Journal of Bioethics* 2015 – both in support and critical of their arguments. In particular, see Chapman (2015), Daniels (2015), Kelleher (2015), Schramme (2015), Sreenivasan (2015), Wester (2015) and Wolff (2015), and the response by Preda and Voigt (2015b). One of the arguments hinges on what is considered to be "avoidable" in the Whitehead

Restricting attention to health gradients as a demonstration of health inequity overlooks a crucial feature of our assessment of the health distribution.[28] As I have argued elsewhere (Anand 2004), we should surely be concerned both with *aggregate* (or average) health as well as with *inequality* of health (around the average) – which I had labelled 'efficiency' and 'equity', respectively.[29] The argument was illustrated by using life expectancy at birth differences between two groups of equal size (Ibid., pp. 15-16). Adopting exactly the same two-group example here, suppose that one group – the bottom 50% of the population ranked by income (or SES) – has a life expectancy at birth (LEB) of 50 years, and the other group – the top 50% – also has a LEB of 50 years. There is perfect equality and no gradient in health between the two groups. Now suppose that over time (or in a different country), the LEB of the bottom 50% increases to 55 years whereas the LEB of the top 50% increases to 65 years. The average LEB of the population is now 60 years, but there is a positive health gradient between the lower and the higher ranked group.

Despite the now positive health gradient – and *pro tanto* health inequity – in the second situation, can we say that *all things considered* (ATC)[30] the first situation with no health gradient or health inequity is better than the second? Even with a positive health gradient, the second situation is surely preferable on aggregate or 'efficiency' grounds – because *both* the bottom 50% and the top 50% of the population have a higher LEB (a Pareto-superior situation). Yet a comparison based solely on health gradients would reach the opposite conclusion. Looking at health gradients in isolation can be misleading, and aggregate health or 'efficiency' must remain an important criterion of non-comparative justice.

Of course, health egalitarians would prefer it if *both* groups in the second situation had an LEB of 60 years, and would even be willing to accept an equal distribution with both groups having a life expectancy *lower* than 60 years (but more than 55 years).[31] The amount of sacrifice of the 'average' (or 'efficiency') for 'equity' that we are willing to accept

definition, including whether this is an empirical or a normative question. As I have argued earlier (see footnote 24), "avoidability" of the gradient often involves a *normative* judgement, even while it furnishes empirical evidence on the social determinants of health.

[28] Note that health gradients (or SES gradients) are not the only type of health inequity. Unjust health differences across racial groups or areas in a country, for example, also constitute health inequities.

[29] The concern with aggregate (or average) health is commonplace in public health – vide the extensive literature on QALYs and DALYs. As Powers and Faden (2006, p. 96) state, "… improving health status is always a goal of justice in public health."

[30] The phrase *pro tanto* means "to that extent" or "other things equal". It is often used by philosophers to contrast it with *all things considered* (ATC) normative judgements. For further discussion of the uses of this concept, see Chang (2004).

[31] How much lower will depend on the Atkinson aversion to inequality parameter ε. The higher is ε, the more is equality valued, so the more we are willing to sacrifice efficiency for equality. As ε tends to infinity, we would be willing to accept equality of LEB of the two groups at 55 years – the minimum of 55 and 65 years – which is the Rawlsian (or maximin) case of a priority weight attaching only to the worst-off group (see Section 10.2).

– in proportionate terms – is the definition of the Atkinson (1970) index of inequality (Anand 2004, p. 16).

As Sen (1992, p. 136) puts it: "No matter which space is chosen for the assessment of equality, a conflict can arise between *aggregative* considerations (e.g. generally enhancing individual advantages, no matter how distributed) and *distributive* ones (e.g. reducing disparities in the distribution of advantages)".[32] He adds: "Indeed, the aggregative-distributive dichotomy is one of the more pervasive issues in social evaluation. Equality – no matter how broadly defined – can hardly be the only concern in any basal space, and aggregative considerations (including the demands of efficiency) tend to have an irreducible status" (Ibid., p. 137).[33]

I addressed precisely this issue in Section 10.2 where both the levels *and* inequality of health were explicitly incorporated through a cardinal system of declining "priority weights" on individual or group health by use of the inequality aversion parameter ε. The parameter ε determines the rate of decline of the weights and allows quantification of the trade-off between aggregate health and inequality of health. This was done by constructing an 'inequality-adjusted average' through what we called '(1-ε)-averaging'.

12. A concluding comment

In this paper I have attempted to analyze the theories and ideas of justice developed by philosophers and, where appropriate, to map these on to the health space. The theoretical literature on justice has advanced considerably over the past 50 years – from

[32] Parfit's (1997, p. 205) 'Principle of Utility' says much the same thing, even though he formulates 'advantage' in terms of 'utility':
"*The Principle of Utility*: It is in itself better if people are better off. When people would be on average better off, or would receive a greater sum of benefits, we can say, for brevity, that there would be more *utility*".
Parfit adds that: "If we cared only about equality, we would be *Pure* Egalitarians. If we cared only about utility, we would be Utilitarians. Most of us accept a *pluralist* view: one that appeals to more than one principle or value. According to *Pluralist Egalitarians*, it would be better both if there was more equality, and if there was more utility. In deciding which of two outcomes would be better, we give weight to both these values.
These values may conflict. One of two outcomes may be in one way worse, because there would be more inequality, but in another way better, because there would be more utility." (Ibid., p. 205, italics in original.)

[33] In formulating advantage in the basal space of capability, Sen (2009, p. 298) states that: "… equality is itself not the only value with which a theory of justice need be concerned, and it is not even the only subject for which the idea of capability is useful. If we make the simple distinction between aggregative and distributive considerations in social justice, the capability perspective with its pointer to an important way of assessing advantages and disadvantages has implications for *both* aggregative and distributive concerns. For example, an institution or a policy may well be defended not on the grounds that it enhances capability equality, but for the reason that it expands the capabilities of all (even if there is no distributional gain). Equality of capability, or more realistically reduction of capability inequality, certainly has claims on our attention, but so has the general advancement of the capabilities of all."

Rawls to Sen – and I have tried here to investigate its relevance and reach in the sphere of health.

Some of the core ideas of justice date back to Aristotle (circa 350 BCE) – "treating equals equally and unequals unequally" (a process fairness notion), and to the *Institutes of Justinian* (around 540 CE) – *suum cuique tribuere*, i.e., "to render to each his due" (a substantive justice notion). Several recent contributions to justice with particular relevance in the domain of health have been discussed in the paper – such as the distinctions between active and passive injustice, substantive and procedural justice, comparative and non-comparative justice, inter alia. In addition, all the major principles of distributive (substantive) justice have been examined in relation to health – viz. equality, priority, sufficiency, and efficiency. These distinctions and principles have been projected to the health space and contrasted with each other to expose different faces of health justice.

I have tried in this study to show that health justice is a broad and inclusive discipline with many faces. The much-discussed topic of 'health equity', as understood and researched by public health experts and others in recent decades, exhibits just one face of health justice. In terms of the distinctions marshalled in the paper, health equity is a comparative substantive justice concept based on the principle of equality in distributive justice. Other comparative and non-comparative substantive justice concepts based on different principles of distributive justice reveal other faces of health justice – such as health priority, health sufficiency, and health efficiency. Procedural justice, both comparative and non-comparative, combined with other (non-distributive) principles and conceptions uncovers further faces of health justice – such as process fairness, compensatory and reparatory justice, and so on. The many faces that we have depicted and analyzed reflects our pluralist approach to the idea of health justice developed in this study.

It is evident that a unifocal or single-dimensional view of health justice cannot be adequate to the task. We must turn to different faces of health justice to address the varieties of health injustice that are observed in the world. Health gradients as revealed through the social determinants of health are not the only kind of health inequity or injustice. There are huge and manifest injustices around us that require remediation – with considerable moral urgency. The identification and diagnosis of redressable health injustices is central to the project of health justice. Health justice has many faces which call for remedial action on numerous fronts – from flattening the social gradient in countries to tackling the stark injustice where billions of people in the world do not have sufficient basic health care or remain unvaccinated against Covid-19.

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