

Abstract: This chapter discusses how justice applies to public health. It begins by outlining three different metrics employed in discussions of justice: resources, capabilities, and welfare. It then discusses different accounts of justice in distribution, reviewing utilitarianism, egalitarianism, prioritarianism, and sufficientarianism, as well as desert-based theories, and applies these distributive approaches to public health examples. Next, it examines the interplay between distributive justice and individual rights, such as religious rights, property rights, and rights against discrimination, by discussing examples including mandatory treatment and screening. The chapter also examines the nexus between public health and debates concerning whose interests matter to justice (the “scope of justice”), including global justice, intergenerational justice, and environmental justice, as well as debates concerning whether justice applies to individual choices or only to institutional structures (the “site of justice”). The chapter closes with a discussion of strategies, including deliberative and aggregative democracy, for adjudicating disagreements about justice.

Keywords: justice, public health, distribution, egalitarianism, utilitarianism, welfare, resources, democracy, capabilities, rights.

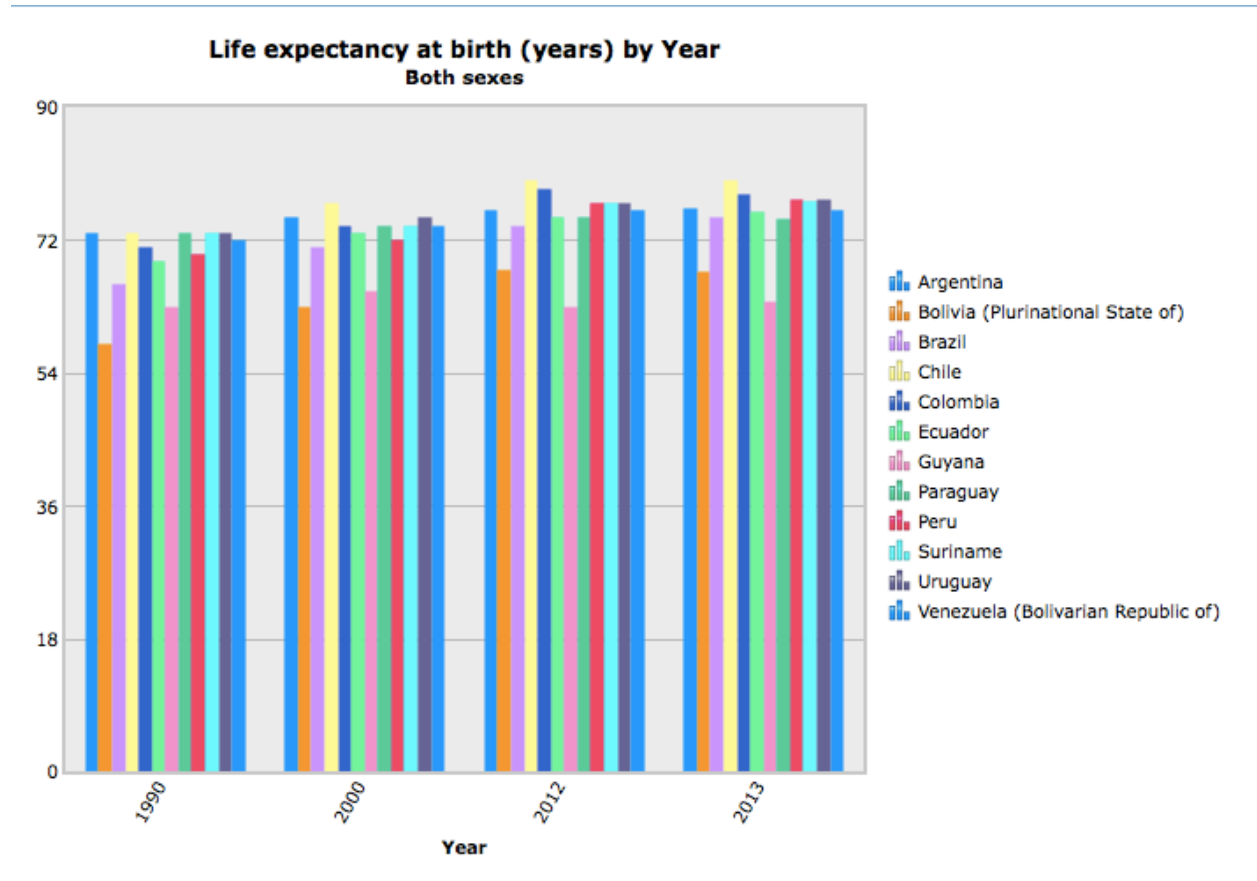
JUSTICE AND PUBLIC HEALTH

INTRODUCTION

Public health is concerned with the health of entire populations and societies. Questions about how our societies ought to be shaped by choices, in public health and elsewhere, are the subject matter of justice. To see how justice intersects with public health, imagine an

international public health researcher—we'll call her Julie—examining a World Health Organization chart of life expectancy in South America (Figure 1).

Figure 1: Life Expectancy at Birth: South America



As Julie examines the chart, she sees that life expectancy is over 80 in Chile, but under 70 in Bolivia and Guyana. These facts present two questions at the heart of justice: first, what are the criteria for a good society; and, second, what differences in what people enjoy within and between societies are acceptable?

At lunch, Julie tells her colleagues about the chart, while they tell her about their public health projects, which include water quality, vaccinations, urban planning, and taxation and

economic policy. Their discussion presents a third question at the interface of justice and public health: which public health interventions will make for a better society? This question has both an empirical component, concerning what outcomes public health interventions will produce, and a normative component, concerning which outcomes are worth seeking. Julie and her colleagues also discuss organizational priorities. Some advocate funding interventions that are already recognized as cost-effective. Others argue for funding new interventions that promise to narrow gaps in life expectancy. Still others worry that some of the interventions, such as changes in urban design or taxes on unhealthy foods, would unfairly burden some individuals or groups. Although these discussions may never explicitly use the word “justice,” they involve the sorts of questions examined in the remainder of this chapter.

WHAT SHOULD WE MEASURE? METRICS OF JUSTICE

Metrics are methodologies for quantifying and evaluating the contribution of various interventions, including public health interventions, to the achievement of a just society. The three most prominent metrics are those that focus, respectively, on resources, capabilities, and welfare (Daniels 1990).

Resources

Resourceist metrics judge the justice of a society by looking at how it distributes resources. John Rawls (1999) proposes a primary goods approach, which has become a prominent resourceist metric. Rawls defines primary goods to include income and wealth, as well as less tangible goods such as rights and social bases of self-respect.

Resourcist metrics make data collection easy and avoid judgments about what a good life is. Some people worry, however, that resourcist metrics are unfair to disabled or ill individuals who require more resources than others in order to pursue their goals or participate in society (Sen, 1985). Familiar resource metrics for public health audiences include gross domestic product (GDP) and per-capita GDP, which measure a society's total and average economic resources.

Capabilities

Capability metrics, pioneered by Amartya Sen (1985) and Martha Nussbaum (2000), look at the distribution of capabilities, which are freedoms to engage in various activities. Nussbaum (2003) lists ten capabilities with universal importance—life; bodily health, bodily integrity; senses, imagination, and thought; emotions; practical reason; affiliation; interaction with other species; play; and control over one's environment—whereas Sen (2004) suggests that the list of capabilities can differ between societies and be developed through public discussion.

Capability metrics emphasize active dimensions of human life, such as choice and agency, rather than focusing on passive enjoyment or resource possession. However, critics worry that they underrate the importance of actual outcomes (Arneson, 2010), and that measuring and comparing capabilities will be difficult and intrusive (Freeman, 2006). In light of the former concern, Ruth Faden and Madison Powers (2006) have developed a metric that draws on the capability approach but focuses on actual functionings—the activities individuals engage in—rather than capabilities, and have applied that metric to public health. The Human

Development Index, which combines life expectancy, literacy, and income measures, also builds on ideas from the capability approach and is widely used in public health (Fukuda-Parr, 2003).

Welfare

Welfarist accounts assess justice by examining the distribution of welfare. Some welfarist accounts define welfare as a subjective mental state of pleasure; others define it as preference satisfaction; and still others define it using a list of objectively valuable experiences (Parfit, 1984, appx. I). All of these approaches face problems, which include concerns about repugnant, expensive, and self-sacrificing preferences as well as concerns that subjective mental states matter far less than the arrangement of external reality (Faden and Powers, 2006; Nozick, 1974). Prominent welfarists include Jeremy Bentham (1789) and Peter Singer (1979), as well as many economists. Welfarist public health metrics include quality-adjusted and disability-adjusted life-years (QALYs and DALYs), which are typically generated via surveys of individuals' subjective experience of different health setbacks (Gold, 2002).

Some public health interventions are similarly attractive regardless of what metric is used. As an example, clean water is likely to improve the resources, capabilities, and welfare of its recipients. For other interventions, however, choices about metrics matter greatly: alcohol taxes appear less attractive under some welfare-based metrics, which assign weight to drinkers' subjective pleasure, than capability or resource metrics, which assign such pleasure little or no weight.

WHO SHOULD GET WHAT? PRINCIPLES OF DISTRIBUTIVE JUSTICE

Along with what to measure, we must also consider how to distribute whatever is measured. *Non-correlative* principles do not try to correlate how much each individual receives with other facts about that individual, whereas *correlative* principles do.

Non-correlative principles

Maximization

This principle maximizes what is available irrespective of distribution. In Julie's example, maximization would favor improving life expectancy by five years in longer-lived Chile over improving it by four years for an equally sized group of individuals in shorter-lived Bolivia. Maximization is often described as "utilitarianism," though that term is more frequently used to refer specifically to *welfare* maximization, as opposed to capability or resource maximization. A frequently discussed basis for public health decisions is maximizing the number of QALYs saved or DALYs avoided (Schwappach, 2003).

Maximization becomes more complicated when public health interventions that change the size of the population, such as family planning, are at issue. Applying a maximization approach to interventions that change population size presents a choice between total and average maximization. Maximizing the average favors a smaller population with a lower sum of whatever is valuable but in which the average individual is better off, whereas maximizing the total favors the opposite. Each view faces problems: the average view is criticized for its

unwillingness to add individuals who enjoy a substantial amount of whatever is valuable to a very well-off population when adding these people would fail to maximize the average, while the total view is criticized for its favorability to policies that produce vast populations who each enjoy little of what is valuable (Parfit, 1984). In an effort to address these concerns, some have attempted to combine elements of both total and average maximization, though no solution appears completely satisfactory (Arrhenius, Ryberg, and Tannsjö, 2010).

Prioritarianism: priority to the worst off

Prioritarian approaches assign special importance to helping those at the bottom of a distribution. Strict prioritarian views, such as Rawls's "difference principle" (1999, 67-73), give absolute priority to the worst off group, while flexible prioritarian views employ a sliding scale of priority on which priority increases as individuals become worse off (Parfit, 1997, 213).

Prioritarian distributive principles have support among health care planners (Ottersen, Mbilinyi, Mæstad, and Norheim, 2008). Incorporating distributional weights into cost-effectiveness analysis, by assigning more importance to QALY increases that go to individuals who are worse off, represents one way of quantifying prioritarian ideas in public health (Ottersen, Mæstad, and Norheim, 2014).

In the WHO example, a flexible prioritarian view might favor a 5-year improvement in Guyanese life expectancy over a 6-year improvement in Brazil, but not over a 10-year-improvement in Brazil. In contrast, a strict prioritarian view will always favor even a miniscule improvement for the worst-off over an enormous one for the better-off. This has prompted criticism of the strict prioritarian view (Arrow, 1973).

Egalitarianism

Egalitarianism aims to reduce inequalities in distribution. In Julie’s example, egalitarianism would agree with prioritarianism that we should give extra weight to improving life expectancy in shorter-lived countries. Strict egalitarianism aims to achieve complete equality, while looser approaches to egalitarianism propose what Elizabeth Anderson (2008) calls “range-constraining rules” that limit the extent of inequality. Many familiar measures of inequality, such as the Gini coefficient (which quantifies the extent to which people’s incomes differ), are employed in public health (Wagstaff, Paci, and Van Doorslaer, 1991).

Though egalitarian and prioritarian approaches frequently make the same recommendations, prioritarians focus on the absolute position of the worst off, while egalitarians focus on the gap between the worst-off and better off. Therefore, egalitarians—unlike prioritarians—will sometimes advocate “leveling down”: that is, they will sometimes object to an improvement that helps the worst off but increases inequality. Leveling down has been criticized by prioritarians (Parfit, 1997), but defended by some egalitarians (Eyal, 2013).

Sufficientarianism

Sufficientarianism ensures that no one falls below a specified threshold (Shields, 2012). Some define thresholds in absolute terms, while others argue that thresholds of sufficiency must vary with social context (Faden and Powers, 2006). The use of poverty thresholds, such as the \$1/day threshold employed in the Millennium Development Goals (Deaton, 2003), represents the

most prominent effort to operationalize a sufficientarian view in a domain relevant to public health. Some human rights documents also define the right to health as a right to adequate or sufficient health (Persad, 2014, 603-04).

As an example, applying a life expectancy threshold at 72 years of age to the WHO chart would support public health interventions that increase life expectancy in Bolivia and Guyana, which have life expectancies under 72, but would be neutral between interventions in Paraguay and in Chile, even though Paraguayans live less long on average than Chileans.

Sufficientarianism, like prioritarianism, helps those worse off while avoiding levelling down. Sufficientarianism has been criticized, however, for ignoring morally relevant differences above or below the selected thresholds (Shields, 2012). Even if improving life expectancy for people in Bolivia and Guyana should be the highest priority, the fact that Paraguayans live less long than Chileans is not obviously irrelevant.

Correlative principles

Correlative principles aim to correlate what people receive with some other dimension of life in which they differ. Three of the most prominent correlative principles correlate what people receive to, respectively, their contribution, their effort, and what they have traditionally received.

Contribution

Some theorists have argued that individuals who increase the amount available to be distributed ought to receive more of what is distributed (Miller, 1990, ch. 6). As an example, past organ donors might receive priority for organ transplants in the future (Persad, Wertheimer, and Emanuel, 2009). Even though contribution-based principles will often reach similar conclusions to the non-correlative maximization principle discussed earlier, contribution-based principles look to past contributions, while maximization looks to future contributions.

Applied to the WHO chart, a contribution-based approach might favor public health efforts that improve life expectancy in Argentina, because the Argentinian economy contributes more to global productivity, over efforts to improve life expectancy in less developed Guyana. In light of the foundational importance of health to people's lives, however, contribution is arguably an inappropriate basis for distributing health, even if it can be an appropriate basis for distributing other goods (Feiring, 2008).

Effort

Others argue that the distribution of goods should be based on individual effort, with those who put in more effort receiving more. One prominent version of this view is advanced by John Roemer (1993), who argues that we should ensure that people who exercise a "comparable degree of responsibility" do equally well, regardless of their background circumstances. Roemer also proposes a detailed methodology for quantifying effort, though this methodology has not been widely adopted in public health.

As with contribution, there is a worry that an effort-based distribution of health will be unjustly harsh on those who exert little effort (Feiring, 2008). Explaining which kinds of effort

should count is also challenging: for instance, even if inefficient farming techniques in Suriname mean that Surinamese farmers exert more effort to produce a given quantity of food than Colombian farmers, rewarding effort that stems from inefficient practices seems like a dubious basis for distributing benefits, including public health benefits. Ultimately, as Susan Hurley (2002) observes, identifying which types of effort matter for distribution seems to require some background account of justice. Once this account has been identified, it is unclear why effort itself matters.

Tradition

A traditionalist view correlates what individuals receive with what they have historically and traditionally received. Applied to Julie's chart, a traditionalist view would attempt to maintain the distribution of life expectancy over time, and so would oppose any proposal that dramatically increases or decreases life expectancy.

Because of their opposition to change and tendency to maintain hierarchy, traditionalist views are often identified with political conservatism and a bias toward the status quo (Brennan and Hamlin, 2004). Such views have also been defended by thinkers, such as Bentham (1843) and David Hume (1739) on the basis of individuals' psychological attachment to accustomed arrangements. In practice, traditionalism frequently obstructs public health innovations that might improve the lives of some but disrupt the lives of others. For instance, some assert that single-payer health insurance will be difficult to enact in the United States because it would disrupt insurance arrangements to which many have become accustomed (Feder, 2014).

Combining principles

Any distributive principle can be paired with any metric (Table 1). For instance, while Rawls pairs a resourcist metric with a distributive approach that favors the worst off, it is also possible—as he himself notes—to combine a resourcist metric with a distributive approach that simply maximizes total resources without any special concern for the worst-off (Rawls, 1999, 277-85).

Some approaches to distributive justice employ only a single distributive principle, while others include multiple principles, which are weighed against one another. Defenders of multi-principle approaches argue that no single principle adequately captures what is needed for a just society (Persad, Wertheimer, and Emanuel, 2009). However, some worry that multi-principle approaches fail to articulate a principled basis for balancing different principles, such as equality and maximization, against one another (Rawls, 1999, 34-40).

Table 1: Metrics and Principles of Distributive Justice

Metrics	Distributive Principles	Prominent Approaches
(a) Resources	<i>Non-correlative</i>	Rawlsian: (a) + (2)
(b) Capabilities	1) Maximization	Utilitarian: (c) + (1)
(c) Welfare	2) Prioritarianism	Faden and Powers: modified (b) + (4)
	3) Egalitarianism	
	4) Sufficientarianism	
	<i>Correlative</i>	
	5) Contribution	

	6) Effort	
	7) Tradition	

WHAT ELSE MATTERS? INDIVIDUAL RIGHTS AND CONSTRAINTS ON DISTRIBUTIVE JUSTICE

Most accounts of justice recognize certain non-distributive constraints on the pursuit of distributive principles. Rawls (1999), for instance, believes that certain basic liberties, such as freedom of thought and association, political participation, freedom of movement, and the right to hold personal property, must be secured before we begin thinking about the just distribution of resources.

Many public health dilemmas involve conflicts between distributive goals and individuals' basic rights or liberties. Many of these basic rights take the form of *negative rights*, which are rights against intervention. For instance, rights to bodily integrity, freedom of association, or freedom of religion might complicate efforts to require vaccinations against a communicable disease or quarantine individuals who show signs of infection, even when these public health interventions would improve population health or achieve a better distribution of health. Some libertarian theories (e.g. Nozick, 1974) regard property rights as absolute and prohibit the imposition of taxes, which would have the effect of choking off funding for public health interventions.

Meanwhile, basic *positive rights*, which are rights to receive benefits, can also obstruct public health goals: for instance, recognizing an individual right to lifesaving health care can consume resources that would otherwise be used to promote public health (Persad 2014;

Schmidt, Gostin, and Emanuel, 2015). Other types of rights, such as rights against differential treatment on the basis of race or gender, can also come into conflict with public health initiatives such as targeted screening of poor women of color for HIV infection (Faden and Powers, 2006, vii-viii) or restrictions on the purchase of unhealthy foods (Kass, Hecht, Paul, and Birnbach, 2014; Barnhill, 2015).

Accounts of justice differ not only in the list of rights they recognize but also in how they handle conflicts between, on the one hand, distributive aims, such as sufficiency or priority to the worst off, and, on the other hand, basic rights and liberties, such as freedom of association or property rights. Some accounts, like Rawls's, give fundamental liberties absolute priority over distributive aims. Others allow rights to be overridden when doing so can dramatically improve distributive outcomes.

WHERE DOES JUSTICE APPLY? GLOBAL JUSTICE AND THE SCOPE OF JUSTICE

Some accounts of justice give equal weight to all interests that are affected by a given decision. But many others give special weight to some interests. Deciding which interests matter is the question of the *scope* of justice.

The most prominent debates have involved *geographical* scope, which separates theories of justice that give special weight to one's fellow citizens from those that do not. The latter are often termed "cosmopolitan" and the former "statist" or "nationalist" (Emanuel, 2012). This division can be moved further in or further out: for instance, some theories may give special weight to fellow members of one's state or city, or to larger collectivities than the nation-state. Geographical scope has clear implications for public health choices: some interventions, such as

vaccinations against communicable diseases, produce great benefits outside a nation's borders, while others have much more local effects.

Other distinctions of scope are also debated. There are, for instance, questions of *temporal* scope (Rawls, 1999, Parfit, 1984): what weight should justice give to the interests of those in the far future or distant past? There are even questions of *biological* scope (Donaldson and Kymlicka, 2013): what weight should be given to the interests of nonhuman animals or of ecosystems? These other forms of scope also bear on public health decisionmaking. For instance, how we evaluate changes in the design of the built environment that affect carbon emissions will depend on what duties we owe to future generations. Likewise, evaluating the burdens that disease eradication may impose on nonhuman animals who are carriers of disease will implicate questions of biological scope.

WHAT CONDUCT DOES JUSTICE EVALUATE? THE SITE OF JUSTICE

Discussions of the *scope* of justice try to identify the physical or conceptual spaces where justice applies. In contrast, debates regarding the *site* of justice try to identify the actions or interactions that are properly assessed by the standards of justice.

One prominent view on the site of justice, associated with Rawls (1999) and Thomas Nagel (1991), regards distributive justice as applicable to the “basic structure” of society, which comprises institutions such as the constitution or other fundamental legal rules that organize society as well as the economy, property, and general rules passed by the legislature. So, for example, justice would apply to decisions whether to impose a tax on unhealthy foods, because these taxes are implemented through binding legislative action. In contrast, distributive justice does not apply to a shopkeeper's decision to sell a large sugary soda to an individual child,

because that decision is not part of the basic structure. While there may be good reasons to criticize the shopkeeper, those criticisms are grounded in morality rather than justice, or at least in forms of justice other than distributive justice.

A different perspective on the site of justice is adopted by G.A. Cohen (1997), who frames it in terms of the feminist slogan “the personal is political.” On Cohen’s view, individual choices such as selling a sugary soda must also be evaluated in terms of justice. For Cohen, there is no clear distinction between rules of law, such as taxes or regulations, and individual choices, such as the shopkeeper’s choice to sell soda to the child: all are subject to the same form of evaluation.

Debates regarding the site of justice are relevant to the question of how broadly justice applies to public health, and which actors within public health systems should be concerned about justice. If Cohen’s view is correct, then Julie’s co-workers who provide direct public health services, such as nurses or epidemiologists in the field, should evaluate their choices in providing care or interviewing people by employing the same principles of justice that apply to structural and legislative decisions. In contrast, if justice applies only to the basic structure of society, then Julie and her colleagues still have reason to care about justice, but providers of direct services can be subject only to norms of professional ethics that are unrelated to, and may deviate from, principles of distributive justice.

Last, many public health interventions—such as antismoking or safer sex campaigns—attempt to shift social norms rather than creating or enforcing binding laws, which raises the question of whether social norms should be evaluated according to principles of justice (Ronzoni, 2008). Social norms are more than purely individual decisions, although norms can be reinforced or threatened by those decisions. However, they are not enforced by the use of

binding legal authority. Nonetheless, social norms can have a pervasive influence on how individuals' lives go.

WHO DECIDES? RESOLVING DISAGREEMENTS ABOUT JUSTICE

The discussion so far illustrates that questions about justice are complex. This complexity produces ample room for disagreement. One place for disagreement concerns choices about how to understand justice: for instance, which constraints to recognize or which metric to use. Another concerns the resolution of conflicts between different aspects of justice, for instance, how to weigh constraints against distributive principles. As they try to decide which public health interventions should receive priority for funding and implementation, Julie and her colleagues may face both these types of disagreements.

Disagreements about justice can be resolved in numerous ways. One way of doing so is democracy: each position is presented to the public, who select what they conclude is the best conception of justice. There are two major strands of democracy discussed by political philosophers, aggregative and deliberative. In aggregative democracy, individuals separately evaluate proposals and vote on them, and their votes are then aggregated to determine which proposal is selected. In deliberative democracy, by contrast, individuals gather together to discuss and debate the proposals under consideration, with their discussions constrained by certain procedural and substantive norms (Cohen, 2009; Gutmann and Thompson, 2004). After the discussions, individuals either vote independently or reach some sort of communal consensus.

Democracy has the advantage of giving each individual's perspective equal weight, and of ensuring that political decisions are responsive to the public. It faces some challenges,

however, in handling certain questions of justice. For instance, determining whose voice counts in democratic decisions requires settling the question of the scope of justice (Goodin, 2007), which makes it difficult to derive an account of the scope of justice from democracy alone. Additionally, if voters are confused or uninterested, they may reach outcomes that are substantively bad, and pure democracy may also reach outcomes that are bad for numerical minorities (Arneson, 2009). Last, real-world decisionmaking processes, even formally democratic ones, frequently give insufficient weight to the voices of poor or socially excluded groups (Young, 2000).

In public health, democracy frequently plays a role in determining whether a given intervention is implemented or a given consideration is accepted as relevant to justice. For instance, votes about whether to tax sugary drinks or unhealthy foods frequently reflect judgments about the justice of such taxation. So do votes to permit regulation on guns in various states and municipalities. Norman Daniels and James Sabin (2002) suggest that an approach they term “Accountability for Reasonableness,” which has affinities with deliberative democracy, can be used to set priorities in a variety of health settings, including negotiations between governments and providers of health care services.

Though some version of democracy is the most popular way of resolving disagreements, alternatives exist. One prominent alternative to democracy for resolving disagreements is to appeal to some foundational moral ideal. For instance, Nussbaum (2003) bases her list of capabilities not on democratic, collective judgments but on an Aristotelian account of what it means for a human being to flourish. Similarly, some utilitarians regard the importance of maximizing overall welfare as a foundational truth to which we can reason by simply reflecting on the nature of human rationality (de Lazari-Radek and Singer, 2014).

CONCLUSION

Just as medicine's emphasis on individual-level dilemmas connects it with individual morality and ethics, public health's population-level emphasis inevitably connects it with political philosophy and with justice. Understanding the landscape of justice will enable actors within public health systems both to evaluate the merits of different public health choices and to compare public health interventions with interventions outside of public health.

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