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Marcos Paulo de Lucca-Silveira

Universidade de São Paulo, Brasil

Democratic Equality, Social Justice and Health

Marcos Paulo de Lucca-Silveira[1]

I

Living a healthy life is a desire for each of us. Healthy living can have intrisic value and/or instrumental value. It is necessary to have a minimum health threshold to accomplish activities deemed valuable and to achieve and conquer the various personal goods and ends we desire in life. However, we may differ on what exactly it is to be healthy. While many crave waking up every day without pain, exhausting fatigue, severe illness or disability so as to be able to meet a strenuous routine of mental and physical work, others consider that an important part of healthy living is being able to live away from exactly these strenuous routines.

One may disagree - and we is likely that we do - on a strict definition of health and perhaps we cannot even individually define what each of us understands, precisely or absolutely, by health or healthy. However, not precisely defining the concept does not preclude us from taking daily individual actions on behalf of our personal health[2]. Avoiding excess drinking and smoking, for example. Many of us seek out physical activities (jogging, gym, pilates or yoga) daily or regularly. At least ideally, whenever possible we aim to eat well. We avoid eating foods with excess saturated fat and for example, choose preferably organic food. We accept in our daily lives that appropriate individual actions can provide us with more time and quality of life (with good health), so that we can pursue and attain our personal or collective achievements.

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[1] PhD Candidate (Political Science) – University of São Paulo, Brazil.
Grant # 2014/12679-0, São Paulo Research Foundation (FAPESP)
E-mail: mpluccasilveira@usp.br
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[2] I will further develop these ideas. The point here is only to emphasize that not defining what "perfect health" is may not prevent making choices and health assessments. An argument such as the following may be plausible: "We may not know what perfect health consists of but we can imagine that the form of such knowledge would be general principles. Yet even in the absence of such principles, we can tell that having the plague is being in worse health than having a sore throat. "(Kamm, 2011, p.85)

However, important dimensions of the population health of a society remain latent if observed from the approach of individual activities and choices[3]. It is necessary to always remember that this "I" that practices the various activities described above, for example, is a person socially situated in a particular economic and social position of a given society. Regardless of our choices, we are part of a system of social cooperation.

Possibly, almost all who read this study identify with the practices and recommendations described above. It is very likely that this is because we belong to adjacent or even similar socioeconomic groups. Certainly, if we are able to opt for a healthy diet (almost always more expensive - one just has to remember the glaring price difference between organic and non-organic food in major supermarket chains) and physical activities (as a hobby), we do not constitute the group of people living below the extreme poverty line. I am not one of the 10 million Brazilians who, even today, live in conditions of complete scarcity, below the extreme poverty line, many of whom wake up without knowing whether they will be able to feed themselves that day[4].

However, it is not only the health of these people in extreme poverty that is affected by the particular characteristics of the society in which we live. Each society, with its particular political, economic and social characteristics, has an impact on the health of its population. This rather generic statement may not appear as a novelty and may not even suggest any wrongdoing or violation with moral gravity. When presenting the complex relationships between political, social and economic conditions and population health from a general "society → population health" correlation (or even causality), much of what matters when we

[3] In this chapter the argument will focus on the issue of the social gradient of the health of population groups, an important dimension of population health that is latent in analyses focused on individual choices. In the next chapter I will argue about the role of individual responsibility in health justice theories.

[4] This would be an approximate number if we use the data provided by the World Bank and assumed that the rate remained the same in the recent period of economic and political crisis. Even with the great advances achieved especially in the last 15 years, 4.9% of the population is still below the extreme poverty line (rate of $ 1.90 a day). Data available at http://data.worldbank.org/topic/poverty (accessed April 19th, 2016). Data on the projection of the size of the Brazilian population are available at: http://www.ibge.gov.br/apps/populacao/projecao/ (accessed April 19th, 2016).

seek to achieve the reasonable ideal of health justice for a democratic society is possibly left hidden.

As stated by important contemporary studies, there is a social gradient in population health of countries (among others, Marmot, 2015). From worse-off social groups compared to those in a more privileged social position, health improves steadily in relation to social position. The higher the socio-economic position of the group, the better their health: longer life in general and the later onset of serious deficiencies[5]. How should we normatively deal with these findings? Can we say that the empirical findings of health inequalities between different socioeconomic groups constitute serious violations of justice in a democratic society?

In this article, I argue that when social, legal, economic and political institutions generate or reinforce arbitrary health inequalities between groups of its citizens, one lives in a very serious situation of injustice. I shall also argue that the reduction of such unfair health inequalities between population groups within the same society, which are a result of complex interactions between the social and population health, takes on a central role when we think of the priority issues of justice, both social as well as health. Thus, I argue that public health policy should make the reduction of health inequities of different population groups one of its priorities. Or rather, in real situations of injustice, such as those experienced by the vast majority of contemporary societies, public policies focused on worse-off socioeconomic groups should be prioritized by democratic states and, moreover, the reduction of the health gap between different population groups should be a central topic of the public policies of a country.

[5] Following the nomenclature presented by Marmot, I consider social gradient in health the linking of social position with social health - higher rank, better health (Marmot, 2015, p.11). A graphical representation of this gradient in England, 1999-2003, (both in life expectancy, as well as in disability-free life expectancy at birth) is available in Marmot (2015, p. 26).

II

When reviewing the relevant literature, one notes that a minimum equality concept is present in the vast majority of contemporary political theories. This basic idea of equality, equal concern, generally defined by the motto of "treat people as equals," can even be considered a basic criterion for the plausibility of contemporary political theories[6]. Extrapolating from books and philosophical debates, we also note the presence of this notion of equality in demonstrations, positions and the political and social demands of various political actors, social movements, and non-governmental organizations, among others. Even though millions of people suffer from severe restrictions on minimum life conditions or have their basic rights violated on a daily basis still today, the public defense of openly inegalitarian positions (those which refuses a minimum of equality) in contemporary political culture, whether in academic literature or in public debates of liberal democratic societies, is not trivial[7]. Fortunately, a belief in the superiority of race, caste or family groups (as naturally superior), seems completely implausible for the vast majority of us[8]. I believe that very few would deny, for example, that, from a moral point of view, it would be a serious omission to deny available emergency care to an individual because of their personal, political, economic or social characteristics[9].

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[6] The notion of a *plateau* of equality in contemporary political theories is present in Dworkin (1977), but also later developed by Kymlicka (2001). In this article I merely want to emphasize the importance of equality in such theories, without necessarily validating the strongest thesis of the need for the value of equality as plausibility criteria for all contemporary political theories.

[7] This does not mean that it does not exist among certain groups. However, I think that the dissemination and defense of these non-egalitarian ideas, in minimal sense, is reduced significantly over time.

[8] As interlocutor, I am considering a citizen of a contemporary liberal-democratic society. Moreover, the argument made here favors local justice issues, which are internal to a democratic society.

[9] In Brazil, denying emergency hospital care, even in a private institution, is a criminal offense (Law No. 2848 of December 7, 1940 -. Criminal Code). Moreover, according to art.135-A of the Law - added by Law. 12653 of 28 May 2012:
"Requiring a deposit cheque, promissory note or any other guarantee, as a condition for emergency medical-hospital treatment : Penalty - detention of 3 (three) months to one (1) year, and a fine .

A minimum notion of fundamental human equality - of equal respect towards each other, the inviolability of human dignity - that applies to, at least ideally, each and every human being, is thus present in both the contemporary political theory literature as well as in the contemporary political culture of democratic societies themselves, with larger and more frequent points of tension and disagreements in the latter. As a sucinct expression of this value, one can cite the first sentence of the first article of the Universal Declaration of Human Rights, "All human beings are born free and equal in dignity and rights." Ideally, at least, we, citizens of democratic and liberal societies of the Western type, do not accept any violation of this article. Even if potentially justified by other principles or by complex and long justifications to demonstrate the specificity of an action that would violate such an article, a violation of this article is never acceptable[10].

However, there is no consensus on the distributional consequences of this notion of equality. Even among contemporary egalitarian theories of justice, which advocate the distributional implications of goods or material resources, there is not an agreement. Some of these theories advocate, for example, that individual choices could justify significant salary differences, if the inequalities derived from unchosen circumstances were met or somehow compensated[11]. Another position, formulated by John Rawls, argues that social and economic inequalities in a democratic society must meet two requirements: in addition to being linked to job roles and positions open to all in equitable conditions of equal opportunities, these inequalities must also be established for the maximum

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Single paragraph. The penalty is increased up to double if denying treatment results in severe bodily harm, and up to triple if it results in death."

[10] Clearly I am making an argumentative generalization, just remember that the Universal Declaration of the Human Rights is constantly used as a justification feature in demands for changes of situations where people currenly find themselves. However, changes in circumstances that flout the basic notion of human rights (such as “basic rights” by Shue (1996)) are priority agendas of various contemporary national states (both locally and globally). There seems to be a consensus on the agenda that everyone, at least if one considers citizens of contemporary liberal-democratic societies, should be guaranteed such basic rights. The delimitation of such rights, on the other hand, it is an open agenda.

[11] We can generically consider that at least some of the "luck egalitarianism" theories (labeled by Anderson (1999)) would accept such a proposition.

benefit of the less privileged members of society. It would therefore be such an extremely rigorous position in the face of the socioeconomic inequalities that may exist in a just society. Thus, contrary to the understanding in a significant part of the economic literature, a correct interpretation of Rawls' theory of justice can not be reduced, or even justify the independent application of a unique maximin criterion - that is, a (re) distribution of a given asset or resource to maximize the "welfare" of the worst situated - in real resource-allocation situations[12].

A social situation where inequalities respect the principles of justice formulated by Rawls - or a notion of egalitarian justice associated with the luck egalitarianism - is clearly far from the situation that the various states of the contemporary world economy find themselves. As a recent piece of literature on exponential growth warns us, we experienced an increase in the already very high-income inequality rates (Piketty, 2014; Atkinson, 2015). Very few people (a few dozen families) control economic and political decisions that directly affect the lives of most members of their states or even globally. Even with these recent high "alarms" being fired by academics, social movements, NGOs, and other groups, we find no significant changes in the scenario.

In Brazil, the richest 1% control about 25% the income in the country, and the richest 10% control over 53%. Add the high concentration of land to this, with 130,000 large rural properties representing 47.3% of the entire rural area of the country and there are 175.9 million hectars of unproductive land in the country[13].

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[12] According to Rawls, for a society to be just, its basic structure should respect his two principles of justice - above I presented the statement of the second principle. Even though the issue of a simplistic understanding of Rawls proposal is constantly raised by philosophers and political theorists, literature in the field of the economy continues to misuse Rawls' theory. In his recent book, Martin Ravallion, despite a caveat about the haziness of certain uses of Rawls in economics literature, also gives an oversimplified presentation of Rawlsian theory, indicating unreasonable consequences of the author's theory (Ravallion, 2016, pp .87-91).

[13] On the issue of income distribution in Brazil, see Medeiros and Souza, 2013; and: https://www.nexojornal.com.br/grafico/2016/04/06/Desigualdade-10-concentram-52-da-renda-no-pa%C3%ADs?utm_campaign=a_nexo_20160407&utm_medium=email&utm_source=RD%20Station

A society with such a socioeconomic profile is far from providing effective access to the social conditions of freedom for all its citizens. Demands of equal respect for citizens are far from being considered. The members of worse-off socioeconomic groups are condemned to live in conditions of sub-citizenship. In this situation, they not only live with severe economic constraints but are also worse off in many other (or almost all) relevant spheres of social life. That is, members of a group that is worse-off economically, will also probably have on average poor health (shorter life and greater number of disabilities and diseases), poor educational background (if not illiterate), poor housing conditions - possibly without adequate supply of basic sanitation, poor working conditions (when not unemployed) and lower social status. Moreover, they are more likely to be victims of violations of basic civil rights by state agents[14] and will rarely achieve equal voice in public and political arenas, among other relevant areas.

This vicious correlation condemning some population groups to live in a complex condition of sub-citizenship (which involves various relevant spheres of social life), leaving them in worse-off positions in various areas of life, is not exclusive to Brazilian society. It is precisely the extinction of this complex condition of sub-citizenship that should also be privileged from a health justice point of view. As contemporary literature emphasizes, all socioeconomic groups below the best-off group have worse health compared to that group (Marmot, 2015 p.11). Even in societies with free and universal access to public health services, such as the Sistema Único de Sáude [*Unified Health System*] (SUS) in Brazil, the health of worse-off groups is inferior to that of the best-off

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On the concentration of land in Brazil, see:
http://oglobo.globo.com/brasil/concentracao-de-terra-cresce-latifundios-equivalem-quase-tres-estados-de-sergipe-15004053

[14] According to official data - which according to various social movements underestimates - in 2014, more than 3,000 people were killed by police in Brazil (compiled by the NGO *Fórum Brasileiro de Segurança Pública*). In the same year, 398 policemen were killed. Another serious violation of basic rights occurs with the people arrested in Brazil. A prison in the country, with a population of over 600,000 people in 2014, is required to keep inmates in overcrowded cells and living in inhumane conditions in the country.
Available Data:
http://www.forumseguranca.org.br/storage/download//anuario_2015.retificado_.pdf (accessed 16 April 2016).

socioeconomic group in the country[15]. Thus, the impact of the broad economic inequality present in societies is not limited to the health of segments of the population that are located at very bottom of economic deprivation[16].

III

It seems hard to deny that there are many unjust inequalities today in Brazil as well as the vast majority of countries. I believe that analysts from different theoretical and empirical approaches accept this general conclusion. However, part of the contemporary normative theoretical debate on justice and health has focused on issues that brush against what I believe to be of central importance.

What do we owe each other as citizens of a democratic society, with regards to the health of our fellow citizens? This, in my view, is the ultimate health justice issue, which should guide normative theoretical debate, even if indirectly. When presenting an answer to the question, the reasons and justification for it must be presented. As Forst stresses (2014), justice is highly relational, as occurs among people in a given context and can not therefore be reduced to define a distribution scheme and allocation of given goods or data resources, or furthermore, the establishment of a reasonable minimum level from which one can live. Consequently, when analyzing issues of justice and population health, we can not forget or move away from the ideal of an equal society, free from the various forms of arbitrary rule or domination[17]. Thus, perspectives that are overly focus on *distribuenda,* even if they have obvious

[15] On the issue of health inequality in Brazil, see, among others, the works of Neri and Soares, 2002; Noronha and Viegas, 2002; Szwarcwald, *et. al*, 2011.

[16] This is the core of the social gradient in health issue as emphasized by Marmot (2015). In this working-paper I am choosing to always present quotes from the most recent work of the author. However the results presented by the author are similar to other previous work. Among other works that study the relationship between socioeconomic characteristics and health of population groups, Kawachi and Kennedy, 2002; Wilkinson, 2005; also stand out.

[17] Forst affirms that domination, "signifies the arbitrary rule of some over others –that is, rule without proper reasons and justifications and (possibly) without proper structures of justification existing in the first place". (Forst, 2014, p.21)

qualities, leave central aspects of a justice perspective underdeveloped. When issues of health justice are simplified to question of what individuals should *receive,* such theories tend to annul the voice and agency of public policies "receivers". Ultimately, such theories come close to the fine line of transforming individuals of a society into passive recipients of public health policies.

The agenda of the legitimacy of "*who* and *how* determines who receives and what it receives" should come to light in health justice theories. The sources and legitimacy of political power are critical from the point of view of justice (Forst, 2012, p.195). To be a beneficiary of a public health policy that provides treatment but generates stigma is very different from being a recipient of a public health policy, which manages the same medical outcomes without stigmatizing effects[18].

The quality of the health of populations is directly related to the degree of empowerment that members of such groups have (Marmot, 2015, Chapter 5). Receiving health resources from a non-democratic state or one with broad levels of economic inequality is very different to receiving the same features from democratic states with low economic inequality. Living in regimes with high inequality takes away power - key category for health quality and justice - from large numbers of economically worse-off citizen groups. Living in non-democratic regimes, fully limits a central dimension of the power of its citizens.

Thus, public health policies should also be developed and justified from a citizen participation process (representatives of various relevant socio-economic groups in society), regarded as free and equal, with special emphasis on groups affected by these policies. Such policies should have clear criteria of scientific/medical validation; however this can not be considered a sufficient criterion for implementation. Public policies that generate significant positive results from a medical and epidemiological view point can cause serious side effects in other spheres of the social lives of the beneficiaries, such as reduced self-esteem or guilt of the beneficiaries, and could therefore not be implemented in democratic states.

[18] The question of stigma is developed by Anderson (1999).

It is also necessary, therefore, that we shift attention from the *distribuenda* to the *distributor* when we reflect on health justice issues. It is imperative to think about the state and the government not as *a priori* neutral actors, but rather we must drive them to treat citizens as equals and act with neutrality to the degree that equality duely requires [19]. Necessarily, such policies must satisfy an *interpersonal test*, where justification, the reasons and real motives of certain public health policies are presented to the representatives of a given society, not only proponents and the scientific community, but also and especially to beneficiaries or those affected by such a health policy[20].

Demands of equal respect should guide the policies of a democratic state, which should ensure its members effective access to the social conditions of their freedom at all times. Situations in which the members of a given socio-economic group are excluded or segregated from participation *as equals* in civil society institutions or in the government are incompatible with the ideal of democratic equality, even if such individuals formally enjoy civil and political rights[21].

Thus, I argue that a significant part of the efforts of public health policies should be centered on the abolition of socially created or sustained injustice. Health policies should therefore express equal respect for all members of society. Therefore, "democratic equality regards two people as equal when each accepts the obligation to justify their actions by principles acceptable to the other, and in which they take mutual consultation, reciprocation, and recognition for granted" (Anderson, 1999, p.313).

The provision of adequate health care and the elimination of arbitrary health inequalities of populations related to economic, political and social conditions are required for members of that society to function as equal citizens. As proposed by Daniels, and as Rawls argues, we have social obligations to

[19] See Dworkin, *Why liberal should care about equality* (1985, p.2015). In this sense, my proposal resembles the liberal position based on equality presented by the author.
[20] I am freely adapting the idea of *interpersonal test* by G. A. Cohen (2008, pp.43-44) to my proposal. This issue will be developed with the advance of research.
[21] Anderson (1999, p.317) calls the situation of people that I seek to describe in this paragraph as "second-class citizenship."

protect fair equality of opportunity, then we have social obligations to promote the health in a population and to distribute it fairly (Daniels, 2010, p.133). Still, in his words, "protecting normal functioning - which I took to be the same thing as health - would make a significant contribution to protecting our opportunity range" (Daniels, 2010, p.133)[22].

In the next section, this study seeks to deepen the analysis of some points of Rawls's theory - especially in the definition of the first subject of justice and the connection between social cooperation and the ideal of justice - to advance the normative argument proposed here.

IV

Justice issues play a special role in political and moral arguments. When we appeal to justice, we claim priority over other values. Injustice is something we should primarily avoid. As stated by the Nagel:

> If a form of inequity in social arrangement is unjust, it should not be tolerated, even if that means giving up things that may be very valuable in other ways. (Nagel, 1997: 303)

The need to circumscribe the scope of justice derives precisely from this priority. Specifically, for the consideration of health justice presented here, it is worth noting that not every claim of population health and especially individual health can be considered a matter of justice according to the terms formulated here. As Rawls argues, already in the opening sentence of the first chapter of *A Theory of Justice*, "Justice is the first virtue of social institutions (...), laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust. Each person possesses an inviolability founded on

[22] In accordance with Anderson (1999) and Daniels (2010), I am in favour of a perspective that intends to integrate the capabilities approach with the Rawlsian proposal of democratic equality (and specifically with the focus on opportunities for health and health care, as performed by Daniels).

justice that even the welfare of society as a whole cannot override "(Rawls 1999: 3).

According to the author, we must consider major social institutions (understood as a systematic set or, in Rawlsian terminology, as the basic structure of society) the first subject of justice. As explained in Conference VII of *Political Liberalism:*

> The basic structure is understood as the way in which the major social institutions fit together into one system, and how they assign fundamental rights and duties and shape the division of advantages that arises through social cooperation. Thus the political constitution, the legally recognized forms of property, and the organization of economy, and the nature of the family, all belong to the basic structure of society. (Rawls, 2005, p.258)

Thus, the first goal of a theory of justice should be the formulation of primary principles that provide reasonable guidelines to address social justice issues related to the institutions of the basic structure. However, what would be the reasons for restricting the primary focus of social justice in the basic structure of society?

According to Rawls, there would be three main reasons for this approach: the basic structure is the first subject of justice because (i) its effects are profound and present from the beginning; (ii) it influences and shapes wishes, desires, aspirations and even the character that people will come to have, and (iii) it ensures the maintenance of the necessary conditions for background justice.

The consequences of the basic structure are profound and present from the beginning (Rawls, 2001, p. 10), considering that the social conditions in which individuals develop (including the relative positions and the means and opportunities available) determine the range of options and choices available to them in life, as well as shaping their interests, objectives and future prospects. Moreover, the inequities resulting from different starting points are especially profound. If, on the one hand, the finding that "society" has an effect on the people living in it seems almost irrefutable, the cunning originality of Rawls's

argument is to displace the general responsibility of these influences of the vague concept ("society") to apply it to certain institutions that are necessary for social cooperation, which constitute the basic structure of society. Moreover, it is the profound influence that the basic institutions have on individuals, conceived as free and moral people with fundamental interests to exercise their moral powers, that justifies the primacy granted to the basic structure of society (Freeman, 2014, p. 95).

In Rawls's theory, the interests and wishes of the people are determined partly by the basic structure and can not therefore be considered as a last entity for justification choices. As Scheffler affirms, in theory of justice as fairness, "[t]he desires and aspirations that individuals happen to have at any given moment enjoy no default moral authority" (Scheffler, 2006, p.104), as occurs with a pre-existing distribution of properties. In the words of Rawls, "the basic structure shapes the way the social system produces and reproduces over time a certain form of culture shared by persons with certain conceptions of their good." (Rawls, 2005, p. 269).

Thus, affiliating to a Rawlsian perspective[23], I think the justice focus should be institutional. I think that is precisely the arbitrary health inequalities (ie. health inequities) between groups that are generated, strengthened, reinforced and legitimized by social, legal, economic and/or political institutions that should be eliminated from a justice point of view.

As I said, according to Rawls, an ideally just society is one whose political, economic and social institutions respect the two principles of justice[24]. Shifting the argument for non-ideal situations, centred on the issue of population health (as I am aiming to present), to formulate public policies that aim to drastically reducing such health inequities of population groups is a priority agenda of this perspective. As Nagel says, "(w)hat is objectionable is that we should be fellow

[23] I use the term "Rawlsian perspective" as it presents a possible development of the Rawlsian theory for real situations of health justice.

[24] I choose to not develop here the specific developments presented by Rawls on health and healthcare (especially in *Justice as Fairness*), and not to thoroughly present Daniels' (1985; 2008) proposal as an extension of Rawls's theory, as they only brush against my argument. This analysis will be present in my PhD dissertation.

participants in the collective enterprise of coercively imposed legal and political institutions that generates such arbitrary inequalities." (Nagel, 2005, p.128)

Returning to the proposal that is being formulated here, it is relevant to answer the question: when are health differences between population groups within the same country unjust and should therefore be reduced? In accordance with Daniels (2008; 2013), a benchmark to answer this question is to consider that health inequalities are unjust when resulting from an unfair distribution of socially controllable factors that affect the health of the population[25]. If it is true that this scope is deliberately broad and general, encompassing both health inequalities between classes, races/ethnicities and gender, amongs relevant others, and enabling varied demands from social movements and other social actors to be included in this label, it is also true that not all health inequalities between groups of a population of a democratic society are considered unfair. For example, the health inequality that results when a religious or ethnic group achieves better health outcomes than other demographic groups due to special diet or restrictive sexual practices would not be considered an iniquity (ie unjust) if appropriate health care and education about health were provided to all population groups (Daniels, 2008, p. 334)[26].

Furthermore, it is worth emphasizing that the perspective is focused on public policies aimed at reducing health inequities in socioeconomic *groups*, prioritizing worse-off *groups*. Such focus on groups (rather than individuals or other units) is connected to the contemporary historical context, since the demands in contemporary democratic political culture manifest themselves from

[25] One suggestion for a response to the question was presented by the World Health Organization (WHO), when it said that health inequalities should be considered inequalities - ie, unjust - when they are avoidable, unnecessary and unfair (Daniels, Kennedy and Kawachi 1999: 225). However, the precise demarcation of these adjectives used by the WHO is not so clear.

[26] The same applies if the reverse case is verified, that is, we do not consider a given religious group - for example, Jehovah's Witnesses - having a lower health index due solely to religious practices and prohibitions (such as the refusal to accept blood transfusions), in a context of appropriate education, health information and fair provision of health care, a health inequity to be combated.

groups (Daniels, 2003, p.242)[27]. As I stated earlier, real situations - where the worse-off socioeconomic groups are subject to a condition of sub-citizenship and correspondingly live less and have worse health - are unjust. People from these population groups can not live freely and as equals, in terms of reciprocity and mutual respect, as they should in a system of social cooperation.

Returning briefly to the theory formulated by Rawls, a clear link between justice and social cooperation can be observed. Synthetically, we can state that, according to the theory of Rawls, only in societies where the institutions of the basic structure respect the two principles of justice, can individuals live freely and as equals, in terms of reciprocity and mutual respect. That is, "as opposed to promoting aggregate happiness or some other good state of affairs, it is the moral quality of human relationships and the political/moral values of freedom, equality, reciprocity, and mutual respect that inform the primacy assigned to principles of justice for the basic structure of primary social institutions "(Freeman, 2014: 96). Thus, the ultimate political and moral value that this perspective has - respect for others as free and equal moral persons who cooperate in terms of reciprocity and mutual respect - can not be promoted by a calculations “machine” and choices of means and situations that optimize or maximize this value. This moral ideal presented by Rawls is "principle-dependent" (Freeman, 2014: 96), ie it can only be carried out from interpersonal relationships of individuals who interact and cooperate according to principles and justifiable rules for procedures exemplifying such a value/ideal.

It is precisely this dimension that must not be left obscure in a perspective of health justice, and it is accessed by the ideal of democratic equality formulated earlier. If it is true that we need to change the situation in which millions of people live today, which impact their health in an extremely perverse way, we can not limit ourselves to present models – even if “egalitarian” models – to distribute or redistribute assets, resources or medicines in strictly more efficient and maximazer standards[28].

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[27] As Daniels also highlights, this focus on groups would be consistent with the theoretical proposal of Rawls.

[28] Examples of these perspectives are, in my view, the works of Roemer (2000; 2002).

These "maximizer models", by not delving into theoretical justification of justice, blur the distinction, therefore, between acts of moral solidarity and acts of justice. Ignoring this difference "can lead to a situation where - in the dialectic of morality, as it were - what is the requirement of justice in the seen an act of generous assistance or aid'" (Forst, 2014, p.20-21). Thus, argumentative power and priority are lost, which are intrinsic to justice issues.

V

Reducing health inequities is not a simple task. As already suggested, the provision of a public, free and universal health care system does not necessarily eliminate the unjust health inequalities between different socioeconomic groups according to contemporary studies[29]. Non-focalised public policies may even end up increasing health gap between different groups in a given society[30].

The legal guarantee of providing universal and free health care, as well as the medications necessary for specific medical treatments, may result in different outcomes in different contexts and times. The constitutional guarantee of health as a right for all and a duty of the state - as set out in Article 196 of the Federal Constitution of the Federative Republic of Brazil (1988) - is an interesting example for us to verify this issue. If it is true that the guarantee was used in claims (judicial and extrajudicial) to press the Brazilian state into ensuring the provision of antiretroviral drugs to the population in the 1990s, and moreover, to establishing a comprehensive public policy on the issue of HIV/AIDS, turning the country into a model for this treatment; it is also true that the growing number of legal claims for drugs and very costly treatments, via individual demands, can result in budgetary and organizational problems regarding public health institutions in the country and in particular, end up having a negative effect on

[29] This does not signify, of course, the refusal of the importance of such health systems. On the issue of the complexity of reducing health inequities, see Daniels (2013).
[30] An example often cited in the literature are the information policies that encourage the reduction of tobacco consumption. These policies tend to be generally more effective in reducing cigarette consumption in more socioeconomically better-off groups.

the inequality of health between social groups[31]. As contemporary studies indicate, the result of the contemporary "judicialisation of health" in Brazil is opposed to the reduction of health inequities[32].

What I think is necessary to always keep in mind is the fact of scarcity. In my view, scarcity, or limited resources, is no mere detail and should be taken into account both in theoretical analyses and in public policy formulation and legal requirements. We must consider that a significant part of important resources and assets is limited and should be distributed fairly among the individuals that make up a system of social cooperation[33].

I think that the principle "for each according to his needs", classically associated with Marx (1977), does not solve the issue of distributive justice if there is scarcity. If the scarcity of a particular good or resource of broad interest is acknowledged, we might need more of this good than we can provide. Not taking this point into consideration can lead to serious distortions.

The legal guarantee to health, to free health care provided by the state, if turned into an exclusive privilege for those who can "enforce" their rights - through legal action, for example[34] - can result in maintaining situations of injustice, reinforcing or even raising the existing health gap between population groups in a country.

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[31] The Brazilian state provides free medicine, which is included in a list written by the Ministry of Health. Many of these legal claims request newer (often expensive) drugs that are not yet included in this list or are not authorised by the National Health Surveillance Agency, or request medication by brand name (associated with a particular laboratory) - bearing in mind that the drug with the same active compound is already included in the list - or different dosages of an available drug.

[32] There is extensive quality literature analyzing this question, on which there no consensus in the literature. But the general opinion that I give here is present in a large part of this literature. The works of Ferraz, 2014, 2011; Oliveira and Noronha, 2011; Wang, 2013 stand out, among others.

[33] In opposition to proposals that speculate on the reduction or extinction of the scarcity of health resources due to the advancement of technology, medicine and science, I think that the reverse may be observed: as a result of these advances, the dilemmas and distributional issues of health resources are more important and usual in societies today and will tend to become even more usual and complex in the near future.

[34] It is important to highlight the existence in Brazil of the *Union's Public Defender* (*Defensoria Pública da União*), which provides access to justice for those who do not have the resources to pay private lawyers (or do not have any link with institutions that pay for them). Specifically on the role of public defenders in court health claims and see Oliveira and Noronha, 2011.

If the argument that I sought to justify is plausible, a democratic state should prioritize public policies aimed at extinguishing the condition of sub-citizenship in which populations are condemned to live in many societies today. A priority on the agenda of state health agencies should focus on policies targeting the worse-off groups. Prioritizing and focusing on public policies relating to these worse-off groups is a duty of a democratic society. Unlike the dicourses present in the current arena, focalised policies, if properly formulated, justified and implemented, and if based on the notion of democratic equality, do not deny equal concern. As I have already affirmed, there is no necessary association between justice and state neutrality/universality of all public policies.

Priority needs to be given to combatting a condition that leads certain population groups to suffer systematic disadvantage. As Faden and Powers state, this systematic disadvantage occurs in a variety of familiar forms in contemporary societies:

> Ethnic and gender-based oppression are paradigm examples, as are pervasive forms of economic and cultural subordination. In each of these, the causal vectors of disadvantage are multiple and mutually reinforcing. In the worst instances, systematic disadvantage exhibits a cascading effect in which each deficiency in one dimension of well-being contributes causally to the reduction of well-being in some other respect (poor cognitive development in relation to health, for example). Multiple strands of the densely woven vectors of disadvantage thereby magnify and increase the risk of negative consequences across the board. The result is that the greatly diminished well-being prospects for those who are systematically disadvantaged are compounded, perpetuated, and sustained over the course of a lifetime, and, frequently, over the course of generations. (Faden and Powers, 2011, p.600)[35]

So, changing the perverse correlation that condemns the worse-off group members to live in conditions of sub-citizenship - suffering from prejudices, poor

[35] It is noteworthy that this would be, for the authors, the negative aim of social justice. The positive aim is the improvement of human well-being, and in the special case of public health institutions, this aim is focally attentive to improving health as one of the most significant dimensions of well-being (Faden and Powers, 2011, p. 598).

education, poor employment and housing conditions, which is directly linked to the poor health of these members, should be a central focus of public policies. Moreover, it is necessary, as highlights Marmot (2015), that we provide empowerment for all citizens. The huge existing socioeconomic gap in much of contemporary societies dramatically reduces the power of many people to control their own lives, and also generates dramatic effects on the self-respect of these individuals. As stated by Rawls, of primary importance, is that a society must provide all its citizens the social bases of self-respect. Living in a condition that condemn you always to be in the worse condition in the various spheres of life that matter to you - forcing you to accept poor conditions of backbreaking work for very low wages, living constant situations of police abuse and prejudice, for example - prevent you from having a "lively sense of [your] worth as persons and to be able to advance [your] ends with self-confidence" (Rawls, 2001, p.59)

Thus, I argue that contemporary democratic states should formulate a significant part of their public health policies prioritizing worse-situated groups in a situation of sub-citizenship, based on ideals of democratic equality, equal respect and self-esteem[36], in which those affected by such policies have their voices heard in the public arena and that such policies be democratically justified to citizens.

No doubt, in a scenario of scarce resources, the question of how much should be prioritized is not simple. Another question that is difficult to answer is related to the appropriate balance, and appropriate deliberations and justifications, including guidelines based on technical and scientific knowledge and other political and social demands of representative groups.

The approach presented here on worse-off population groups is not the only one that matters. Health inequalities are even more urgent when “they are avoidable and when they co-travel with clusters of disadvantaging determinants that undermine multiple dimensions of well-being (Powers and Faden, 2006, p.98). It seems undeniable, for example, that a state should prioritize public

[36] On the notion of respect (and self-esteem) and its important role in health, also see Ricoeur, 2007.

policies aimed at reducing child mortality especially when the child and newborn mortality distribution is significantly high.

Finally, I would like to add that, in addition to arguing that the issue of shortage should always be considered, I also advocate an integrative perspective that aims to overcome an alleged dispute over public resources by the various relevant areas/public agencies. A careful analysis of social gradients of health allows us to state that health policies do not dispute resources with educational policies, water policies or basic sanitation, among others. All these variables impact population health[37]. The results of these various specialized policies have an impact on population health. The distribution of resources has to be understood as cooperation, not trade-off. However, what is also necessary to emphasize, is that broad economic policies of democratic states should not be adopted without taking into account their impact on the health of various population groups. A just democratic state is incompatible with such great economic, political, social and health inequalities that are observed in Brazil and many other countries today.

[37] This does not mean that, “exclusive” public health policies can not have a significant impact on the health of citizens.

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