An enquiry concerning justice in health, or what ethical account best informs health policies aimed at tackling health inequalities.

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Abstract

The present thesis investigates the role of justice when informing health policies such as the reforms of health systems or those aimed at tackling health inequalities.

I set the problem as a case study derived from the reforms of the Chilean health system and the inequalities in health, especially those related to access and financing of healthcare and those derived from the pervasive inequalities in the determinants of health. Departing from the challenge that inequalities in health represent for us, I explore some of the alternative accounts that inform the debate regarding the organisation of the health system in Chile and continue my research questioning the concept of justice that will inform an account of justice in health.

The outcome of this research is the development of a virtue-based account of justice in health that rescues the important role of virtuous agents to carry out just actions regarding health. Specifically, recognises the role of institutions as primary agents of justice in health, and the necessity to perfect their capacities to deliberate and act accordingly to render what they owes to the people they serve, i.e. to accomplish their right to health.

Acronyms

AUGE	(System of) Universal Access with Explicit Guarantees in Health
AVPP	Potential Years of Life Lost
CASEN	National Socioeconomic Survey
CESCR	Committee on Economic, Social and Cultural Rights
DALY	Disability-Adjusted Life Year
DESAL	Department of Health Economics
FONASA	National Health Fund
GEGA	Global Alliance for Monitoring Equity and Health Systems Consortium
INE	National Statistics Institute
ISAPRE	Private health insurance institutions
MIDEPLAN	Ministry of Planning
MINSAL	Ministry of Health
MISP	Ministry of Internal Affairs and Public Security
NHS	National Health Service
NV	Live Births
PAHO	Pan American Health Organization
SEGPRES	General Secretariat of the Presidency
SdS	Health Watchdog
WHO	World Health Organization

Contents

Introduction

> ‘For this Government, there is a right to health. However, this simple statement is not enough for protecting the right to health; it needs the establishment of explicit [health-related] guarantees, namely access, opportunity, quality, and financial support. For doing so, it requires the instruments for generating an effective exercise of the right to health, by giving the users the power and mechanisms for claiming them.
>
> The health reform has one only North, that is, to give all the Chileans the best health care through the AUGE Plan, avoiding the present inequalities.’
>
> Presidential Address to the National Congress (Lagos, 2002)

I was a privileged witness of the debate that led to the health reform during President Ricardo Lagos term in office (2000-2006) when I was junior advisor to the minister of health. During that period, I had the chance to observe and participate in discussions with people with different backgrounds—either political or academic—regarding what and how the health system should be reformed. I did realise that even though there was a shared diagnosis of the situation and good evidence in favour of technical solutions proposed to reform the Chilean health system, most of the difficulties to advance in agreeing a new system were rooted in the different philosophical accounts that inform the ideological backgrounds of the political parties of which the actors in the debate were members or at least sympathisers. I was aware that an ideological background implies that one adopt a position—regarding any political debate—standing from the point of view of such an ideology. However, what captured my attention then was that the debate barely went upstream to the source of such differences; obviously, it happened because it was a political not a philosophical debate!

As I was interested in go deeper in such a philosophical debate and my own background was weak to do that (Medicine, Paediatrics and Health Administration), I enrolled to pursue a master degree in Bioethics —at the same time the reform was approved and began to be implemented. My master's thesis, entitled 'Inequities in Health in Chile: The Limits of Chilean Health Reform from an Ethical Perspective'[1], deals about the constraints the reform was confronting to accomplish what was intending to do: namely, (1) to realise the right to health by establishing explicit guarantees regarding healthcare, and (2) to reduce inequalities in health (See quote of President Lagos at the beginning of the chapter).

After I obtained the 'Master in Bioethics' degree, I decided to enrol in a PhD program as I realised that this would enable me to do a more substantive contribution for new policies in health—going upstream in the ethical foundations of such policies when required. Although I have not obtained the PhD degree yet I can affirm that doing the research for this thesis has being an incredible support to take better informed decisions as Vice-Minister of Public Health, position I occupy since 2014.

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[1] Original title in Spanish is: 'Inequidades en Salud en Chile: Los límites de la reforma de la Salud Chilena desde una perspectiva ética'. The Master degree was awarded at the Catholic University of Chile.

The thesis I am submitting now *'An enquiry concerning justice in health, or what ethical account best informs health policies aimed at tackling health inequalities'* is the reflection not only of the academic research that I have carried out during the long period of time I have needed to complete it. It is also product of my own process of maturation as a policymaker dealing with decisions regarding public health during that period of time.

As the title indicates, this thesis concerns the search of an ethical account that best inform health policies that aim at justice in health, especially when they are intended to reduce health inequalities. I use the case of Chile for three reasons, namely: (1) it is the case I better know and the one that motivates this research, (2) it is a well-known case of application of radical neo-liberal reforms—including a health reform—that led to a fast economic growth but increased social inequalities—which in turn motivated a new health reform in recent times, and (3) such a reform confronted political positions with clearly identifiable accounts of justice.

The thesis is divided into three parts. In the first part, I intend to delineate the problem that motivates this enquiry. In the second part, I intend to configure what I think should be a better account of justice to inform health policies to tackle health inequalities. Finally, in the third part I explain how this account was useful to contribute to inform the creation of a system to address the problem of high-cost treatments.

Part I: 'Delineating the Problem', consists of three chapters. The Chapter 1 starts with a short description of the formation of Chilean health system and the reforms implemented. It focuses particularly in two substantial reforms that the Chilean health system has undergone: the neo-liberal reform carried out during Pinochet's dictatorship and the egalitarian reform of President Lagos. I then describe confronting theories of justice that inform the main actors in the debate regarding health reform in Chile and the difficulties to match these theories to the practice. Chapter 2 focus on the problem of health inequalities that concerns to any health system—but it is especially problematic for a country characteristically unequal like Chile— and the moral justification to seek reducing such inequalities. In Chapter 3, I intend to go further on explaining why it is important to tackle health inequalities on Justice's grounds and why a different account is required to inform health policies for that purpose.

Part II: 'A Justice Account to Inform Health Policies' contains two chapters. In Chapter 4, I elaborate the basis for an account of Justice departing from the concept of justice that will inform such an account. Chapter 5, in turn describe the components of the concept of justice I developed when it is to be applied on health issues.

Part III: 'Justice in Health and the Problem of High-Cost Treatments' contains just one chapter, the number 6, which describes the problem that emerged in Chile regarding high-costs treatments –that are not included in the AUGE system created in the recent reform– and have a catastrophic financial. Later, this chapter describes the system created to afford the problem of high-costs treatments for which the account of justice described in the second part was a useful input to inform its design.

Finally, the thesis finishes with the Conclusions, where I intend to summarise the findings of this enquiry and raise further questions to afford in future research.

Part I: Delineating the Problem

1. The Chilean health system

1.1. The history of the Chilean health system and its reforms

The history of the Chilean health system[2] begins with the Spanish colonization of the territories of what is now known as Chile, when they established the first hospital in Santiago in 1552—eleven years after the city was founded. It is possible to recognise several milestones during this history that makes of Chile an innovator in the organization of its health system in the context of Latin American countries (Jimenez & Bossert, 1995; Bossert & Leisewitz, 2016). Some of these milestones were the formation of a Board of Health in 1805 to vaccinate against smallpox; the creation of the Board of Directors of Hospitals and Shelters in 1832, giving a public role to the private charity hospitals; and the establishment of the General Bureau of Health in 1887, as the first public health authority.

The first quarter of the twentieth century witnesses the consolidation of the public health functions through the enactment of the first 'Sanitary Code' (Law No. 3385, 1918) which established public responsibilities regarding sanitation and preventive health programs; and the adoption of a Bismarkian system[3] for health coverage, through the Social Security Law (Law No. 4054, 1924). Chile was one of the first countries in implementing such a system after Germany.

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[2] According to the World Health Organization a health system consists of 'all the people and actions whose primary purpose is to improve health' (WHO, 2000):1 or more specifically 'all organizations, people and actions whose primary intent is to promote, restore or maintain health' (WHO, 2007:2).

3 The Bismarkian system is also known as Social Health Insurance; it was first introduced in Germany in 1883 by Chancellor Otto von Bismarck through several so-called 'sickness funds'
that had mandatory enrollment and defined benefits (Carrin & James, 2005; Bump, 2010)

Later, Chile performed the first large reform to its health sector, adopting a National Health Service (Law No. 10383, 1952) that organised the public and private providers into one integrated system for primary, secondary and tertiary healthcare, and financing it through both social security contributions and general taxes revenues. The Chilean NHS was the product of eleven years of debate in the National Congress, which begun in 1941 when the legislators of the then ruling Popular Front[4] introduced a bill to create it. Through that debate a wide consensus across the political spectrum from communists to conservatives was reached. One of the driving forces to attain such as a consensus was data confirming the inequalities between unprotected poor families compared to workers' families with social security protection, such as a mortality rate ten times higher (Jimenez & Bossert, 1995 p.160). The main focus of NHS was maternal and child health; therefore, programs were progressively developed aiming at improving their health status. They were highly effective: significantly improved maternal and child health and nutrition, tackling communicable disease rates. The infant mortality rate dropped from 136 per 1000 live births in 1950, to 33 per 1000 live births by 1980; the prevalence of malnutrition among children at age of 6 years declined from 37% to 11.5% (Jimenez & Romero, 2007). The wide consensus about the objectives and characteristics of the NHS remained during almost three decades since 1952, even though different political parties and coalitions succeeded the Popular Front in government such as Nationalists (1952-58), Liberal-Conservatives (1958-64), Christian Democrats (1964-1970), and finally Marxists-Leninists (1970-1973) that were deposed by the *coup d'état* led by General Augusto Pinochet (1973-1990).

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[4] The Popular Front was integrated by the Radicals (Social Democrats), the Socialists, the Communists and other minor Left wing parties. It governed Chile from 1938 to 1945.

1.2. A neo-liberal reform of Health System

Pinochet's dictatorship was ideologically inspired by the Doctrine of National Security, which emerged in Latin American countries as the outcome of the anti-communist counterinsurgency training—in the context of the Cold War— developed by the U.S. Army School of the Americas (SOA) since 1946 onwards (Viera-Gallo, 1978; Calvo, 1979). Its focus on national security was the centre of the political development that resulted in the instauration of a new Constitution in 1980 (Bertelsen, 1989). Nevertheless, Pinochet's regime also adopted a neoliberal social and economic agenda that led him to impose a private property market economy in Chile (Fischer, 2009). Similar to the influence of SOA over the Chilean military officers, it was the influence of the University of Chicago's School of Economics: since 1955 onwards—thanks to an alliance with the Chilean Catholic University—many Chilean young economists pursued postgraduate studies there working directly under Milton Friedman and Arnold Harberger tuition. These economists, known as 'Chicago Boys', formed the economic team that implemented radical economic reforms during Pinochet's dictatorship (Valdés, 1995). This process was later reinforced thanks to the influence of two important world leaders—Margaret Thatcher and Ronald Reagan— and the role played by the World Bank and the International Monetary Fund: loans given to developing countries were conditioned upon reducing the size of the state's and its involvement in the economy, allowing the private sector to get involved in areas that had been previously understood to be a priority or exclusive area for the state. This was the so-called 'Washington Consensus'.

The reforms carried out by Pinochet's Chicago boys were intended to reduce the role of the state and infuse competition and individualism into areas such as labour relations, pensions, education and health. The former Pinochet's minister of health, Air Force General Francisco Herrera made a series of declarations to Chilean newspapers during 1974 to explain their plans:

> 'We are moving gradually from a statist health system —without giving up free attention to the needy— to a concept of free market, which is something complex and difficult and for that reason, it has to be done with caution, but with audacity and aggressiveness, also with decision' (Herrera, 1974 as cited in Tetelboin & Salinas, 1984 p.365).

> '1975 is the year of transition for the incorporation of health to the free market economic policy of the government; payment of health care must relate to the ability of citizens to afford it proportionally to family income' (Herrera, 1974 as cited in Raczynski, 1983 p.13).

The neoliberal influence was key in the evolution of the role assigned to the state in the area of health. For instance, the Constitution of 1925 emphasized the state's role as guarantor of Public Health as part of the 'social rights':

> 'It is the duty of the State to ensure the public health and hygienic welfare of the country. Each year, enough money [from public budget] must be destined to maintain a National Health Service' (Chilean Constitution, 1925, Art 10 No.16).

The Constitution of 1980, enacted by the dictatorship, promotes the idea of the protection of health from the standpoint of individuals, and emphasises individual freedom to take care of one’s own health. The new Constitution, aims at reducing state’s intervention in the implementation of health actions —through guaranteeing the freedom to choose either private or public healthcare— which determined the existence of two healthcare systems operating in parallel:

> ‘It is the primary duty of the State to guarantee the implementation of health actions, whether undertaken by public or private institutions, in the form and manner prescribed by law. Every person shall have the right to choose the health care system that they wish, whether public or private’ (Chilean Constitution, 1980 Art 19. No.9).

The reform led to the decentralization of the National Health Service —creating the National System of Health Services—, the transference of primary care to municipalities, and the creation of the National Fund of Health (FONASA) (Decree No.2763, 1979). Later, a new decree (Decree No.3, 1981) allowed the creation of private health insurances (ISAPRE), which were intended to gradually replace the social security.

Therefore, Pinochet’s health reform transformed the once integrated Chilean healthcare system into a mixed public-private system as much in the provision as in the financing of services, aiming at the introduction of market economy to allocate resources for health. According to Rafael Caviedes (Caviedes, 1995) —former Director of FONASA during the dictatorship— these changes were based on four principles, namely Individual Liberty, Justice, Property right and Subsidiarity. Individual Freedom consisting of the right to choose the health insurance, or to choose the health care provider as well as the freedom to decide how much of their resources are devoted to health-related purposes. Justice in this case would mean *to each one according to his contribution*, which implies that each one receives health care according to how much he/she pays, directly or through a health insurance. Property right implies the right to decide the fate of one's own possessions, for example, deciding how much to expend in health insurance. Subsidiarity implies state intervention for health actions only when choice cannot be made by the individual or private sector initiative, so as to ensure an acceptable minimum.

The reforms made during the '80s of twentieth century, combined with the effects of the economic crisis in the first half of that decade, led to a strong reduction of the fiscal contribution to the health sector that resulted in the deterioration in access and in the quality of care for the Chilean people with low and middle incomes. For its part, the private insurance system showed a series of failures such as exclusions for those with pre-existing conditions, low coverage in the area of catastrophic risks, risk discrimination and lack of transparency in prices and coverage.

After the restoration of democracy, the first two terms in office of the Center-Left coalition '*Concertación de Partidos por la Democracia'* (Coalition of Parties for Democracy) focused on regaining public investment in the health sector, especially in hospitals infrastructure —strongly deteriorated in previous years— starting a significant program of investment, associated with the recovery of endowments and wages for public sector workers. The intention of President Eduardo Frei (1994-2000) was to carry out a significant reform to the health system. However the administration failed to overcome the obstacles imposed by the lack of a shared vision within his coalition and heavy pressure from labour organizations. Frei had to postpone his reform plans given alternative priorities such as the educational reform and judicial reform. Nevertheless, Frei's administration introduced important changes to the organization and the financing of healthcare system, in order to provide greater equity and efficiency within the public healthcare system: strengthening FONASA, implementing new payment systems such as the '*per capita* payment' to primary care providers and the 'diagnostic-associated' payment at hospital level; and creating new programs aimed at specific problems such as the Opportunity Attention Program to reduce surgical waiting lists, the Catastrophic Insurance program and the Elderly program .

At the end of the first ten years of Centre-Left coalition in office, a number of problems in the Chilean healthcare system still persisted, such as unequal access to healthcare, weakened public hospitals, lack of regulation of the private system, an inadequate model of care to address the demographic and epidemiological changes, and inadequate funding directly used for the realisation of benefits (Lenz, 2007).

1.3. The recent reform of the Chilean Health System

The Health System reform became one of the iconic achievements of the administration of Ricardo Lagos, getting broad political and academic support, as well as social support for the transformations generated (SdS, 2008). This reform—carried out between 2002 and 2005—aimed at (1) to realise the right to health by establishing explicit guarantees regarding healthcare, and (2) to reduce inequalities in health, recognising and guaranteeing equal access to healthcare and equalizing health conditions to correct the inequities in health status.

An important precedent for this reform was the World Health Report 2000. In its introductory message former WHO director Dr. Gro Harlem Brundtland states:

> ‘The report breaks new ground in the way that it helps us understand the goals of health systems. Clearly, their defining purpose is to improve and protect health – but they have other intrinsic goals. *These are concerned with fairness in the way people pay for health care, and with how systems respond to people’s expectations with regard to how they are treated.* Where health and responsiveness are concerned, achieving a high average level is not good enough: *the goals of a health system must also include reducing inequalities, in ways that improve the situation of the worst-off’* (WHO, 2000 p.viii. Italics are mine).

The world health report 2000 presented for the first time an index of national health systems’ performance in trying to achieve three overall goals: good health, responsiveness to the expectations of the population, and fairness of financial contribution. Among 191 countries, Chile ranked: 32nd for good health; 45th for responsiveness; and 168th (!) for financial fairness (WHO, 2000 p.152). Effectively, even today Chile is a country characterized by significant social inequalities, and within them, health inequalities are prominent (PNUD, 2017).

For the time the reform was proposed, there were clear conscience that Chilean health system had good results in global health indicators—like life expectancy and infant mortality— that consistently improved in the country during previous decades. Infant mortality had decreased from 32 per 1000 live births in 1980 to 10.1 per 1000 live births in 1999, life expectancy had increased from 67 years in 1980 to 75 in 1995-2000, and general mortality had diminished from 6.6 per 1000 inhabitants in 1980 to 5.3 in 1999. Nevertheless, not all socioeconomic groups benefited equally from these improvements. There were notorious differences between rich and poor communities, for example for the life expectancy at county level. For 1996, male life expectancy at birth ranges from 66.1 to 85.7 year according to the socioeconomic condition of the county; for females, the range spanned from 73.3 to 84.7 years (Vega 2002). The infant mortality was 5 times higher in those infants born from mothers with less than 8 years of education as compared with those born from mothers with 12 or more years of education (Hollstein 1998).

The reform started through a process of prioritisation of health problems, setting up four 'Health Objectives for the Decade 2000-2010' (MINSAL, 2002). Based on them, the ministry of health defined specific goals in priority areas, setting up the general strategies for achieving each objective, including evidence-based interventions in the areas of promotion, prevention, treatment and rehabilitation. The four objectives were:

1. Improve and maintain successes in health already achieved.
2. Address the challenges of population's ageing and other changes in society.
3. Reduce health inequalities.

4. Provide services that meet the needs and expectations of the population.

The document 'Health Objectives for the Decade 2000-2010' additionally explains that to achieve equity through healthcare interventions it is necessary to reduce the risks and improve health status of those most vulnerable—those who belong to disadvantaged socio-economic groups. The document explicitly appeals to the general principles of justice developed by Rawls in his Theory of Justice which should help to define 'those inequalities in health corresponding to inequities' (p.229). Similarly, it states that to determine the justice of a distribution of health status, it is necessary to know the causes and determinants as elements that must necessarily be addressed to achieve an equitably distributed health status.

After delivering the document about health objectives, president Lagos' administration presented a bill to create the System of Universal Access with Explicit Guarantees in Health (AUGE) (MINSAL, 2004)[5]. This system constitutes the core of the reform as it establishes the rules for the progressive specification of patients' entitlements regarding to their right to health. According to these rules, the ministry of health would progressively determine a list of prioritised health problems and the corresponding medical procedures and interventions that the patients must receive.

Each explicit guarantee is characterised through four dimensions (Sandoval, 2004):

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[5] Law 19966 that establishes AUGE system, together with the Law 19,937 that reframes Health Authorities and laws 19895 and 20015 that regulate private healthcare insurances (ISAPRE) constitute the legal framework of the reform of the Chilean health system.

- *Access*: the levels of healthcare —namely primary, secondary or tertiary care— required for each health intervention included,
- *Quality*: the standards for clinical practice and procedures that practitioners and institutions that deliver health care —either public or private— must comply,
- *Opportunity*: the time limits set to deliver care, and
- *Financial Protection*: the financial coverage for each intervention, so that people who have a health problem included in the regime do not see their situation worsened due to the expenses involved in treating the disease.

Law 19966 establishes that every three years the Ministry of Health must dictate a decree a listing AUGE health problems and the interventions required for their treatment. Such a list must consider: (1) the burden of disease, (2) the effectiveness of interventions— in terms of their contribution to the extent of life or the quality of life— and (3) their cost-effectiveness. The cost of the interventions included in the decree should not exceed the budget the Ministry of Finance determines for funding interventions in the public healthcare system.

1.4. Confronting accounts of justice in the health system reform

The preamble of AUGE's bill stated that health reform the Government was intending to carry out was based on five principles: the Right to Health, Solidarity, Efficiency, Social Participation and Equity. The meaning of each principle is summarised as follows:

- The *Right to Health* is the right of every person living in Chile to have a social protection mechanism of universal access to appropriate health care, and the existence of healthy conditions in their community and work within the capabilities and resources of the country.

- *Solidarity* is the effort of the Chilean society to guarantee that the most vulnerable people will receive the same as those who are better off.

- *Efficiency* is the principle to make the best use of available resources, obtaining the best possible results with those resources.

- *Social Participation* involves recognizing people as users and citizens, so that they can express their preferences and expectations for improving health policy through transparent mechanisms for information and participation.

- On Equity, the bill states: 'Equity in health is a moral imperative that is at the root of the will to reform. Healthcare reform aims at reducing avoidable and unfair inequalities, by way of giving greater social protection and universal access to healthcare. [...] Equity is the result of an intentional action to identify and reduce factors or conditions that cause avoidable inequalities and so we must devote our best efforts' (Lagos, 2002 VI.Viii.).

The Government of President Ricardo Lagos opted for the use of a concept of equity in health whose primary object is the equal access to and utilization of healthcare services, but also aims at the factors that determine an unequal distribution health, specifically to the social determinants of health. This concept—as mentioned above—would be informed specifically by Rawls' account of Justice, and seeks a distribution of health that contributes to a democratic equality. This explicit statement is representative of one of the competing accounts or theories of justice that informed the confronting positions regarding the reform of the health system. It is possible to group such accounts into three: (1) *Egalitarian theories*, which informed the platform of the centre-left coalition that pushed for the reform of the health system; (2) *Libertarian theories*, which in turn informed the centre-right coalition; and (3) *Utilitarian theories*, which although would not inform a specific political coalition, is traditionally regarded as important in informing health policies and policymakers.

1.4.1. Egalitarian theories

Egalitarianism generally involves favouring some kind of equality, based on the idea that all people have the same value in moral terms; so it covers a wide range of views, from *Marxist* to *Liberal* Egalitarianism (Arneson, 2002). However, the use of the term here refers more specifically to theories that emphasises *equality of rights*, especially those who fall into the categories of civil, social and cultural rights such as the right to vote, the right to education, and the right to health (*liberal egalitarianism*). The importance of such rights is not given by any intrinsic value attached to the right, but by the degree of freedom that the state can ensure to individuals through the protection of such rights. These accounts challenge the identification of freedom with private property, based on the fact that the free market creates less advantaged social groups. The members of such groups are in a situation of less freedom than those from more advantaged groups.

One of the most important theorists of Liberal Egalitarianism is John Rawls. His Theory of Justice proposes that a just society is one whose social institutions satisfy certain principles of justice —accepted by the individuals who make up society—assigning rights and duties fairly, i.e. without making arbitrary distinctions between them. Rawls thinks that the key task of those interested in justice is to understand 'Justice as Fairness'. On his view, justice's primary object is the basic structure of society, meaning the basic arrangement of social institutions[6] to distribute rights and duties, as well as the distributions of goods (Rawls, 1971 pp.3-16).

Rawls builds upon the conception of the social contract, understanding society as a cooperative endeavour, characterized by common as much as conflicting interests. Rawls' approach is that the object of the original agreement of the social contract, are those principles of justice that the social institutions that constitute the basic structure of society must satisfy. People — as free and rational individuals, looking after their own interests — when placed in an initial position of equality, would accept certain principles of justice that specify the types of social cooperation, regulating all subsequent agreements and forms of government that can be established. These principles of justice should specify how the rights and the duties are to be determined, and the fair distribution of the benefits provided by a shared life.

The initial position of equality implies that, at the origin of the social contract, all people have the same rights to choose principles, in so far as (1) they have a

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[6] Some examples Rawls gives of such social institutions are: the Constitution, the freedom of thought and conscience, market competition, private ownership of the means of production, and the monogamous family, among others (Rawls, 1971 p.6).

conception of what is good for them and (2) they have a sense of justice. However, a condition for choosing such principles is that, at the origin, people will not know what position they will have in that society (they are behind the 'veil of ignorance'), as a way to exclude bias arising from any individual advantage or disadvantage due to either natural or social contingencies, which would mislead the choice of principles of justice (Rawls, 1971 pp.17-21).

In the context of deciding behind the veil of ignorance, according to Rawls people would choose two principles: (1) the principle of equal basic liberties and (2) the principle of fair equality of opportunity and differentiation.

The first principle means that 'each person [is] to have rights equal to the most extensive basic liberty compatible with a similar liberty for others' (p.67). In talking of basic liberties, Rawls understands this to include political freedom (the right to vote and be elected), freedom of speech, freedom of conscience and thought, the right to physical integrity, the right to ownership and the 'rule of law'.

For its part, the second principle holds that social and economic inequalities are just only if they produce benefits for everyone, and particularly for the least advantaged; and offices and positions are open to all under conditions of fair *equality of opportunity*. This is what Rawls calls 'Democratic Equality' (pp.65-73), which must provide the social base for self-respect, and the belief of citizens that the horizon of life is fair.

Amartya Sen is another influential contemporary thinker within the framework of egalitarianism. He criticises Rawls because of the importance he gives to the expectations of primary social goods as the basis of interpersonal comparisons, and not to the relationship between people and goods. According to Sen, Rawls does not take sufficient account of the differences that people take advantage of in relation to the use of such goods in terms of welfare, whatever the meaning we give to this term. Thus, Sen develops the concept of capabilities with which he intends to emphasize the urgency with which certain goods are required by the people. He mentions, for example, the ability to move, ability to feed, to provide oneself with clothing or shelter and have power to participate in the community (Sen, 1980, 2004 and 2006).

1.4.2. Libertarian Theories

Libertarian theories focus on two fundamental aspects: individual liberty and the right to property. This results in the state's duty to ensure that nothing and no one can interfere with what the individual wants to do with his property or with himself, not even the state (Fisher and Gormally, 2001). This leaves in the hands of every individual the freedom to improve his/her circumstances and protect his/her health, according to their own initiative (Beauchamp and Childress, 2001). Its promoters support the thesis that free market is the only legitimate method of allocating resources, relegating the state to a minimal role—just to guarantee that free market will function without interferences that might be directed to some determinate distribution (Hayek, 1966 p. 615).

Libertarian theories were boosted during the 1980s, thanks to the coincidence in political leadership in the United States and the United Kingdom, two enthusiastic supporters of these theories: Ronald Reagan and Margaret Thatcher, who generated a global trend focused on the reduction of the role of the state and minimization of its participation in all sectors. Chile became one of the exponents of this view.

From this philosophical standpoint, Robert Nozick (1974) suggests a conception of justice consisting of impartial mechanisms operating on property transactions: that is, justice is conceived of as a procedural concept. A fair distribution is the one that gives everyone that for what he/she can claim a proprietary right, so that justice is based not on equality of outcome between people, but in respect for private property, as well as the free acquisition and transmission of property. Therefore, justice is possible under three principles (1) the principle of just acquisition of property, (2) the principle of fair transfer of property, and (3) the principle of rectification of those acquisitions or transfers that have not been conducted in accordance with the law. 'The whole principle of distributive justice simply says that a distribution is just if everyone is entitled to the possessions that [they] possess under the distribution ... If the properties of each person are in justice, then the full set (the distribution) of the properties is also fair' (Nozick, 1996 p.235).

In the field of health, another representative of libertarian thought, Milton Friedman, who was mentor of the Chicago Boys (See 1.2), argued that government involvement in health care is a major cause of the problem of rapidly growing costs and lack of availability of medical care. According to Friedman, such an involvement leads to an increase in bureaucracy and therefore increased expenditure and fall in production; it is what he calls ‘Gammon’s Law’ or 'Theory of bureaucratic displacement'. The solution to this is privatisation of health care and major reduction in the role of government (Friedman, 1992; Friedman, 2001).

The libertarian theories critically influenced the vision of healthcare as a commodity, i.e., an asset that it is feasible to purchase or to sell, allowing the free market into both the provision of health services and health financing; reducing state action in this field to guarantee the compliance with and the correct functioning of such a market. This is the account that inspired Pinochet’s reforms to health system in Chile and is still core of centre-right coalition political platform.

1.4.3. Utilitarian Theories

From a utilitarian perspective, the moral value of an action is given by the contribution such an action makes to general welfare or utility, which may be understood as the sum of total pleasure (classical utilitarianism) or the satisfaction of preferences (preference utilitarianism) (Gandjour and Lauterbach, 2003).

On this view of justice each individual counts for one and no more than one. Duties and Rights will depend on ‘convenience’, i.e. how much they contribute to maximizing the utility, so each right has no intrinsic value, but is justified through the contribution it makes in relation to welfare (Beauchamp and Childress, 2001 p.231). The relevant matter is that the rules governing the distribution of advantages and disadvantages maximize the utility or welfare.

The importance of health in this context lies in the contribution that it makes to overall well-being. From a utilitarian standpoint, maximizing health contributes to the maximization of utility, but it is not the only factor that determines the maximization of the latter, so it must be reconciled with wealth maximization and other goods that act as means of increasing welfare (Gandjour and Lauterbach, 2003 p.237). This raises the basic foundation of health resource allocation according to criteria of cost-effectiveness (Dolan, 2001).

The use of measures of disease burden (e.g. DALYs)—which aim to encompass both the lifespan and quality of life—is a way to bring health to the concept of wellness. This allows to assign a common parameter to compare health with competing goods. For instance, if an intervention is more cost-effective it means that contributes most to welfare maximization and therefore should be privileged, regardless of who are the recipients of this intervention and the position they occupy in the social map (Anand and Hanson, 1997). We must note that cost-effectiveness studies are not related *per se* to justice. It is its use in making decisions to allocate resources to interventions that benefit some people and not others what should be examined in terms of justice (Fisher and Gormally, 2001 pp.55-70) .

1.5. Matching Theory and Practice in Chilean Health Reform

Even though president Lagos' reform had its inspiration in Rawls' Theory of Justice as a philosophical framework to define equity in health (See 1.3), the fact that we live in a democratic society —and the need to reach political support to carry out the reform—

forced the Government to reconcile its reform project with the ideas of those who supported the health system reform carried out by the Pinochet's government, which was inspired instead by a libertarian standpoint, emphasizing freedom and identifying equity with equality of property rights that fully justified the introduction of market as a system for the allocation of resources. Thereby, the reform had to keep market as a major force to allocate resources in health system, being only possible to introduce few regulations intending to reduce market failures while maintaining the freedom and property rights as major constraints on equality.

An important issue regarding the concessions made to get political support to carry out the reform was the maintenance of the mandatory contribution in health on a fixed seven percent of salary. For those who earn less, this means a greater burden on their budget than for those who earn more—which becomes a regressive system. Moreover, middle class people affiliated to FONASA contribute twice to finance the poorest (those with no income) through the redistribution of their contribution within FONASA, and through the general taxes they also pay. Thus, while society as a whole is making a contribution to benefit the most disadvantaged (as it is intended from a Rawlsian perspective), the greatest effort is made by those who have a salary which is not high enough to affiliate to an ISAPRE, so they affiliate to FONASA. The government's initial proposal to divert 3/7 of the mandatory contribution of ISAPRE affiliates into a 'Solidarity Fund' that would benefit FONASA affiliates had to be dismissed. In the end, the view that ISAPRE affiliates have a property right over their mandatory contributions to the private insurance they choose prevailed. This had the result that the division between private and public system created by Pinochet's reform —one system for 'the rich' and other for 'the poor'— remained.

A different sort of difficulties, which is necessary to acknowledge, is that there are technical problems in designing a reliable system that realises an account of justice put in terms of equality of opportunities—and not in terms of health access or health status; for example, the definition about what should be guaranteed requires cost-effectiveness analysis. Effectiveness implies the reduction of a health problem, for example, in terms of burden of disease in the population, using the intervention that is being studied. However, calculating the burden of disease does not reflect the inequitable distribution of a health problem. In other words, one could compare the burden of disease, such as between two or more communities or social classes, which may show inequalities, but when studying the effectiveness of an intervention, it is usually done by comparing before and after an intervention in a population whose characteristics (income level, education, health system, etc.) are not relevant as part of that analysis (MINSAL, 1999).

Likewise, it is possible that some interventions will eventually show high cost-effectiveness for problems that are more prevalent among people in a better socioeconomic status, whereas interventions for problems more prevalent among those in a worst-off position are not that cost-effective, leading to prioritising the interventions that will further benefit the better-off.

The use of cost-effectiveness analysis has more to do with a utilitarian view of health policies, as it privileges the sum of, for example, years of life lost due to premature death (PYLL) avoided by the intervention (See 1.4.3) One of the background studies supporting the definition of the Health Objectives of the Decade 2000-2010, the 'Study of cost-effectiveness of interventions for major public health problems', by the Ministry of Health acknowledges that:

> 'A health system is efficient if it is able to maximize the health status of the population given the resources available to it. Under this approach, the health of a person of high income and one of low income has the same value' (MINSAL, 1999 p.8).

A final element of adequacy has to do with the focus within the margins of egalitarianism. As described previously, in theory the government seeks to lead health policy to the achievement of a more equitable health status, for which interventions are needed to reduce the effect of the determinants of the inequitable distribution of health status. But the core of the reform is focused on clinical interventions; meaning that the reform primarily aims at equalizing access and utilization of healthcare system resources. The reason for this is subordinated to another objective of the reform: the idea of fulfilling the constitutional right to health protection, requiring concrete guarantees that any citizen can claim effectively, before the appropriate health authorities or before the courts of justice (See 5.1). The problem is that in this way, the process of allocating resources in health, at the end of the day, prioritises the satisfaction of individual rights, instead of interventions that could affect public health or even the social determinants of health, which hardly could be claimed by somebody before the health authorities or a court of justice.

Summing up, Chilean health system reform builds upon an egalitarian standpoint about justice. Nevertheless, to carry out the intended reforms, Government had to make some concessions regarding its original proposals, as a consequence of the political negotiation with representatives of political parties that disagree with the egalitarian point of view and support the supremacy of liberty and property rights. Additionally, the scarcity of instruments to prioritise health interventions in terms of the 'democratic equality' (measuring for example the equality of opportunity gained with one or another intervention), had to be fulfilled with instruments that are usually in use in the field of Health Policy, as the analysis of cost-effectiveness. Such instruments are more related to a utilitarian point of view as they are intended to maximize the overall health status, and do not take into account the existence of inequities in health

The characteristics of the system of guarantees and prioritization mechanisms set up with the reform process had the effect that the priority for public policy is to give access to health services and not to correct the social determinants that impact health of people and determine inequalities we see today.

Thus we can conclude that the contingencies met in advance of reform, coupled with the presence of different criteria of rationality on health equity, have caused the reform to end up assigning equity in health status a value that ranks lower than the value of individual freedom and the welfare maximization in terms of utility.

The contradiction between the egalitarian aspirations declared by the Government, with the outcome of the democratic procedures, which by the game of majorities and minorities leads to outcomes that do not always fulfil our greatest aspirations, puts into question, in the first place, whether justice criteria reside or not in establishing reasonable and accountable procedures, as the liberal theory tell us, or they are only formal criteria which are part of a wider framework to build a just health system. Particularly, we can ask ourselves whether the problems found in the development of the healthcare reform are just practical problems that keep the theory in a strong position, or they are demonstrating the weaknesses that such a theory has, demanding from us to overcome them exploring alternative accounts to give a better theoretical framework that inform the policies we can develop in order to reduce or eliminate inequalities deemed as inequities. This is the objective of the enquiry we present in this thesis.

2. Inequalities in health

2.1. An emerging problem for both health policy and ethics

During the 20th Century, many developing countries experienced big changes that improved living conditions for both individuals (income, education, nourishment) and population (drinking water, waste disposal). Such progresses summed to an increase in medical knowledge and technological development led to a dramatic improvement in people's health through the enhancement of the quality of life and extension in life expectancy, as never seen before.

The substantive fall of mortality rates and the rise in life expectancy, together with the progressive fall of fecundity rates, resulted in significant changes to the age profile of the countries —less children and more elder people— as has happened before in developed countries. Additional to the ageing of population, the control of infectious diseases has changed the epidemiological pattern of disease, with the result of an increasing proportion of people affected by chronic and degenerative diseases. These large-scale changes in age and epidemiological transitions raise new challenges, forcing governments all over the world to perform significant reforms to their healthcare systems.

Along with the ageing population and the shift in the epidemiological burden of disease, another element has emerged as a feature of the changes occurring in health over the last decades: the unequal distribution of the gains in terms of health status between social groups within each country and between countries.

Inequalities in health status have been recognized to exist for a long time —at least from the mid-nineteenth century (Whitehead, 2000; Deaton, 2002). In England, William Farr described in 1841 health inequalities such as the higher rate of suicide among manual workers, relative to social groups with higher levels of education, thanks to the mandatory registration of deaths that began in 1837, incorporating age and cause of death, and the occupation of the deceased.

However, over the last three decades inequalities in health have received growing attention from public health practitioners and researchers, and from national and international organizations. It is only since the 1970s that the problem of health inequalities begins to have a greater concern strongly driven by the Conference on Primary Health Care held in Alma-Ata in 1978, as part of the global movement Health for All. Its final declaration states:

> ‘The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries’ (International Conference on Primary Health Care, 1978).

In the early '80s, the Report on Health Disparities delivered by the group led by Douglas Black for the Department of Health and Social Services in the UK (Black Report) marks a milestone in the study of health inequalities. The study demonstrating, on the one hand, the relationship between poverty and disease, and on the other hand, that health inequalities had increased despite the establishment of the National Health System (NHS) in 1948 (Black, Townsend and Davidson, 1982). The report suggests that inequalities were not due to a failure of the NHS, but to social inequalities: namely employment, income, education, quality of housing, food and work environment (Crombie, Irvine, Elliott and Wallace, 2005).

Accumulated evidence after the Black Report has contributed strongly to delineating the concept of the Social Determinants of Health that—beyond the influence of genetics and biology—could help explain the incidence and prevalence of certain diseases, and therefore should be included in the design and planning of health policies (Graham, 2004, Graham and Kelly, 2004; Baum and Harris, 2006). Employment, income level, educational level, environment and housing, are some of the determinants that are directly related to health status both individually and collectively (Kelly, Morgan, Bonnefoy, Butt and Bergman, 2007).

2.2. Facing the challenge of health inequalities.

The evidence that there is a deep and growing gap in health status between rich and poor countries, and within countries between the rich and the poor, has been generating a growing concern about the problem of inequalities in health both in the academic world, and amongst governments and international organizations such as the World Health Organization, the Pan American Health Organization, the World Bank, the International Monetary Fund and the Inter-American Development Bank (Birdsall and Hecht, 1995; Bobadilla 1998; Braveman, 1998; Carr, Gwatkin, Fragueiro and Pande, 1999; De Kadt and Tasca 1993; Whitehead, 1992; PAHO, 1996; WHO, 2000).

In Chile, the concern about inequality has also been shown in technical and academic research within the health sector (Florenzano, Pino, Kaplán, & Burrows, 1995; Larrañaga, 1996; Hollstein, Vega, & Carvajal, 1998; Bitran, oz, Aguad, Navarrete, & Ubilla, 2000; Kaempffer & Medina, 2000; Arteaga, Astorga, & Pinto, 2002; Bossert, Larranaga, Giedion, Arbelaez, & Bowsers, 2003; Araya, Rojas, Fritsch, Frank, & Lewis, 2006; Tugwell et al., 2006; Gideon, 2007; Gonzalez et al., 2009; Vásquez, Paraje, & Estay, 2013), and has progressively involved other important areas of society. Authorities and other relevant actors in national political life have taken progressive awareness of the need to re-orientate public policies in order to reduce such inequalities.

The concern to address the problem of health inequalities seems to be related to our most intimate sense of justice (Cribb, 2005; Sen, 2006; Daniels, 2008). *Prima facie,* such inequalities emerge before us as an unfair situation, because we intuitively consider health as a special type of good, which has been called a 'merit good' - i.e., a good whose distribution should be determined by the distribution of other goods, such as wealth or education (Musgrave, 1987). However, the mere impression that growing inequalities in the health field are not compatible with justice is not sufficient to design and justify health policies to address the problem. Not all health inequalities are considered unfair, for example, the longer life expectancy of women relative to men.

2.3. What justifies seeking to reduce health inequalities?

Although the mere observation of inequalities does not necessarily imply that something is morally wrong—since some health inequalities could be considered 'normal' variations— in many cases the existence of inequalities in health will be held to be either a moral problem itself or the consequence of a moral problem. What is it that makes us think that some inequalities in health are morally wrong? It is a very important question; however, from the point of view of those governments and agencies dealing with health inequalities, although it is relevant to know when such inequalities are morally wrong, it is also important to know what morally justifies actions aimed at reducing or eliminating such inequalities. It is a separate concern whether or not people ought to change a state of affairs that is morally wrong. Most of us could agree that to lie is morally wrong, but few would think that this could justify focusing public efforts on seeking to reduce lies within society.

Before moving forward, looking for the answers to these questions, it is necessary to clarify what we mean by the concept of 'health inequalities'. When we talk about health inequalities, we might be referring to different but related aspects of health, namely health status (typically measured by life expectancy at birth, infant mortality or mortality rates, etc) or access to healthcare (i.e. health services use and financing). Which aspect of inequalities in health matters most depends on the point of view of who is analysing the problem (Gwatkin, 2000; Oliver & Mossialos, 2004). The current focus of attention is set mainly on inequalities of health status; maybe because such inequalities remain or even continue to grow, despite the reduction of inequalities in access to healthcare (Gakidou *et al.*, 2000). Since the Black Report was published (Black *et al.*, 1982) epidemiologists and social scientists have continued to reveal evidence to support the idea that a large proportion of actual health status inequalities derive from social inequalities —namely, variations in socio-economic status, gender, race or ethnicity, migration history, degree of urbanization, and religion or caste (Acheson *et al.,* 1998; Braveman *et al.*, 2004;

Contoyannis & Forster, 1999; Graham, 2004; Marmot, 2006; Marmot, 2002; Nuffield Council on Bioethics, 2007; Peter, 2001). For this reason, '*health inequalities'* has been widely used as a term to refer to the inequalities in health between the more and less socially-advantaged groups of a population (Braveman & Gruskin, 2003; Braveman, 2003). However, health inequalities are not only socially determined —there are also health inequalities determined by biological or genetic determinants as well as individual choices. Therefore, it seems clearer using the term *social inequalities in health* when referring to inequalities derived from *social determinants* of health like social advantage/disadvantage*,* and to reserve the use of the broader term *health inequalities* for use as a broader concept that refers to 'the differences, variations, and disparities in the health achievements of individuals and groups' (Kawachi *et al*., 2002 p.647).

2.4. What is it that makes us think that some inequalities in health are morally wrong?

This is a tricky question, as evaluating something as morally wrong may depend on the standpoint of who is asking the question. In the case of health inequalities, an utilitarian could say that health inequalities are morally wrong because they affect the total utility within a society (Woodward & Kawachi, 2000); a libertarian would say they are wrong insofar as they affect acquisition and transfer of goods; even an egalitarian answer might depend on what sort of equality is at stake, namely equality of opportunities, equality of wealth, equality of rights, or the like. Nevertheless, what it is captured by the claim of moral wrongness of certain kinds of state of affairs—such as health inequalities— is that it is unacceptable in a normative sense; in other words, this state of affairs is beyond what ought to be accepted according to a value judgement (Scanlon, 1996).

Some inequalities in health, such as an infant mortality rate for black infants that is twice that of white infants in the same country or, that rates of infant mortality may be three or more times higher across groups of mothers with different educational attainments, are usually judged an unacceptable state of affairs. The unacceptability of some inequalities in health—such as these—derives from the value judgement that they represent some kind of self-evident injustice, or raise a sentiment of injustice when they are contemplated. However, self-evident injustice or a sense of injustice is certainly not enough argument to qualify inequalities in health as morally wrong; the relevant issue is that we can use the 'point of view of justice' as a reference point from which we can morally judge such a state of affairs. It suggests that justice is—at least— a reasonable starting point to respond to what it is that makes health inequalities wrong in a moral sense (Daniels, 2008; Woodward & Kawachi, 2000). This is not a novel idea, many people support the thought that we should reduce health inequalities departing from the point of view of justice, as far as they represent *health inequities*—this is to say health inequalities 'deemed to be unfair or stemming from some form of injustice' (Kawachi *et al.*, 2002 p.647). In other words, there would be a moral duty to alleviate or eliminate health inequalities when they are inequities; therefore, the concept 'health inequities' incorporates a normative value related to justice: *we ought to be committed to reducing or eliminating health inequities*. Some people, going further, suggest that where such inequalities are not deemed unjust, there would be no duty to alleviate or eliminate them (Wilson, 2011).

The obvious question following from such a normative statement is 'what inequalities should fall under the category of inequities?' However, another question that could modify whatever we answer to this question seems prior to it; namely, do we have a *duty* to reduce health inequalities even when they are not inequities? We have just two possible answers to this question: Yes or No. Let me start with a 'No': if this was the case—we do not have a duty to reduce health inequalities that are not inequities— we can put such inequalities deemed as inequities aside and just concentrate on those inequalities that fall under the category of inequities. But if the answer is yes—*there is* a moral duty to reduce health inequalities, even though they are not deemed unjust—then, whatever our account of justice was, it should be able to account for the reduction of health inequalities both inequities and non-inequitable inequalities.

Whilst it is commonly accepted that justice provides a good reason for reducing health inequities—independently of what 'justice' means— it is not clear *prima facie* that justice could justify reducing health inequalities that are not deemed unjust. However, it is a fact that some actions in the field of health are intended to reduce inequalities in health that are not considered inequities. For instance, some such interventions aim at equalizing differences in health status derived from biological variations—or from freely chosen health-damaging behaviours (Rogers, 2007). In such cases, one might appeal to justice to justify such actions but one alternatively might appeal to other values such as beneficence, solidarity, or the like, as a means of justifying such actions.

Whether the latter was the case, a question raises: values such as solidarity or beneficence do impose a moral obligation to reduce or to eliminate health inequalities in the same way justice seems to do? There are two possible answers to this question: The first is to recognise that there is a plurality of values that cannot be weighed against each other as they are incommensurable values. If this were the case, there is no chance to give priority to one over the other; it would require having an account of each value to be used to support the moral obligation to reduce inequalities. In other words, it would require that a possible action to reduce non-inequitable health inequalities would be deemed a moral duty on grounds of solidarity or beneficence, albeit not in justice.

Yet, a problem emerges when competing alternative actions to reduce health inequalities are to be valued, if some of the possible actions are justified on justice grounds—for reducing health *inequities*—and the alternative actions are justified on beneficence or solidarity grounds—to reduce non-inequitable inequalities. It might be argued that justice always acts as a trump value that always overrides the other values; however, it is a fact that many times this is clearly not true. For instance, using resources in expensive treatments for elderly people with chronic terminal disease—that will not increase significantly their life expectancy— instead of using such resources for correcting inequities in access to healthcare for low-income people.

The second way to justify a moral obligation to reduce health inequalities not deemed as unjust is to do so by appealing to justice, not directly, but indirectly *through* solidarity and beneficence. For doing this, it is required to have an 'inclusive' conception of justice that includes other values such as solidarity or beneficence. This idea is compatible with Aristotle's distinction between the idea of something being just and being equitable (Aristotle, 1934 V.10). According to Aristotle, both concepts are the same (substance) but the latter is a better *form* of the previous. What is implicit in this formulation is the idea of movement or change, where justice moves to achieve all its potential. Within this account, solidarity and beneficence would not be competing values but part of the complete form of justice, helping to improve the actual form of justice.

In summary, we might argue that health inequalities are a matter of justice; and if so, there will be a moral duty to alleviate health inequalities—even those that are deemed non-inequitable inequalities. However, to justify such a conception of justice we have to appeal to a broader and more inclusive sense of the concept of justice than that usually employed; one in which justice is not only invoked in a narrow sense to correct something unjust, but used in a broader sense that includes other positive values, namely solidarity, beneficence and the like. How can we approach this broader conception of justice we require to justify seeking to reduce health inequalities?

3. Health Inequalities and Justice

3.1. Justice and Distributive Justice

I shall start my approach to a broader conception of justice recalling that it is usual to divide justice into several—sometimes overlapping—types, such as *Distributive Justice* (fair distribution of benefits, resources, opportunities, advantages, responsibilities and burdens resulting from social life), *Commutative Justice* (fair accomplishment of agreements), *Retributive Justice* (fair rectification of wrongs), *Procedural Justice* (fair process resolving disputes or allocating resources), etc. (Buchanan & Mathieu, 1986).

The 'health inequalities' problem is usually analysed from the point of view of distributive justice, so the accounts developed to inform actions regarding health are mainly looking for the *fair distribution* of health or health-related things. However, if we were to assert that health is something belonging to individuals, then it may also be a matter of either commutative justice or retributive justice. An example of health as a matter of commutative justice would be the agreement of some workers to put themselves at risk of illness through their work or directly doing something that may result in deterioration to their health status. What is a just agreement when health is part of the 'transactional costs'? Similarly, when detriment to health is the outcome of someone else's action, certainly he/she should repair or rectify it, providing the resources for healthcare or compensating for that loss of health with other goods, for instance. However, what is a just compensation for damage to one's health?

Should we have different theories of justice in health for each type of justice, then? Namely 'theory of distributive justice in health', 'theory of commutative justice in health', ‘theory of retributive justice in health’, etc. In fact, I do not wish to support such an idea. What I want to emphasize is that health is a matter for justice in general, not only for distributive justice.

Certainly, the kind of questions emerging from commutative or retributive problems related to health may well receive an answer through an appeal to some criteria of distributive justice. It might be argued that a just agreement should give the worker an equal or higher level of opportunities, or perhaps that a just compensation for health damages would return the damaged party to the same or a higher level of opportunities than that before the damage.

For if we are to consider health as being somehow special, even though we apply distributive criteria to commutative or retributive situations, these situations remain special cases that require further attention. Even so, we shall recognize that a large part of health inequalities are the consequence of some kind of distribution, so it seems a good strategy for working towards an account of justice for health inequalities to think in terms of distributive justice as a starting point. However, we have to bear in mind that this is part of our strategy to find a broader account of justice, able to deal with distributive as much as retributive and commutative claims—in the same way it is able to justify aiming at reducing health inequalities even those that are not inequities.

3.2. Distribution of what?

Distributive justice is concerned with the fair distribution of those things that particular individuals are to share (Finnis, 1979 p.166). According to Rawls, the main task of distributive justice is the choice of the social arrangement that constitute the basic structures of society. The principles of justice as fairness applied to these basic structures use the notion of *pure procedural justice* to deal with particular contingences (Rawls, 1971 p.274). This means that, whatever the outcome of a distribution might be, it is just if the social arrangement ('the procedure') is fair (p.83)— as far inequalities are to the greatest expected benefit of the least advantaged and attached to fair equality of opportunities. Moreover, it would imply—if distributive justice's locus is not the outcome, but the process of distribution—that the health determinants are the proper subject matter for distributive justice, rather than health itself.

However, if our concern is with the distribution of health as an outcome, *pure procedural* accounts of justice —such as Rawls' one— may not be the right account to justify reducing health inequalities. In that case, the account that we seek might be either a 'pure outcomes' approach (only the outcome matters), or a sort of 'mixed' account where both procedure and outcomes matter.

Whatever we choose, setting an account where outcomes matter requires defining what particular outcomes are to be deemed *just* outcomes. So, at this point it is worth saying that some special characteristics of health make it more difficult to set the parameters for defining a just distribution of outcomes in relation to health. First, the health of individuals is not the product of a simple acquisition or transfer from a hypothetical common share. It is not possible to distribute health as we distribute, for example, a cake. Multiple factors determine health —genetics, environment, social factors, or the like; so, there is not a direct relationship between what it is possible to distribute directly through an action performed with the intention of ensuring a just distribution of health outcomes, and the outcome that is, in fact, finally obtained. Neither, is it possible to re-distribute health to correct inequities in health —for instance, taking health from a very healthy person and giving it to a very unhealthy one (Wilson, 2011).

Second, health is more than just the absence of illness. Consider for example, a healthy person who reads in a newspaper that walking 30 minutes every day could raise one's 'sexual performance'. We cannot say that by initiating this daily routine, this person goes from illness to a healthy state, but maybe from a healthy state to a healthier one. Therefore, health is not just one of two alternatives in a health/illness dichotomy. Similarly, health does not exclude illness. Sometimes, people who have a disease are otherwise healthy —for instance, people who use glasses. If health and illness do not completely exclude each other, then the distribution of health does not necessarily mirror the distribution of illness, which is the way we usually measure health distribution—through morbidity rates, DALYs, and so on.

Finally, health has an intrinsic as much as an extrinsic value. Most accounts of health distribution focus on extrinsic value. For example, Daniels' account places a special value on health insofar —through health protection— we are protecting the normal range of opportunities open to individuals (Daniels, 2008). The same can be seen in Sen's account, where health is valued because it is 'a critically significant constituent of human capabilities which we have reason to value' (Sen, 2006 p.22). I am not claiming that no intrinsic value is assigned to health in such accounts, but it does seem that the extrinsic value of health is more important for them.

To relate inequalities in health to justice, especially if we are looking for a framework for justifying health-related interventions—namely, allocating resources to health care, promoting health or preventing illness—and not-health-related interventions, it is usual to begin by drawing upon some general theory of justice.

Daniels, for instance, develops his account of justice in health by extending Rawls's *Theory of Justice* to justify our concern about health. His claim is that in protecting health we are protecting the *normal range of opportunities* open to individuals (Daniels, 2008 p.30). Such a normal range of opportunities is 'the array of life plans reasonable persons are likely to develop for themselves' (p.43). Daniels suggests integrating health (indirectly) into Rawls's index of primary goods by considering health-care institutions as social basic institutions aimed at providing equality of opportunity. However, he states that *opportunity*, not *health care* is the primary good (p.57).

Founding the importance of health in the opportunities it provides is contentious. Even drawing upon Rawls' theory as Daniels does, some other authors do not link the moral importance of health inequities to opportunities; instead, they prefer to include health directly within the list of primary goods (Veatch, 1989). Others, in contrast, prefer justifying the concern about health inequities just insofar as they are evidence of unfair basic institutions (Peter, 2001).

In a broader debate about justice, the different possible 'currencies of justice' (Cohen, 1989) expand the range of options beyond the boundaries of Rawls' theory. For example, the Egalitarian may justify reducing health inequalities either on the basis of the equality of *welfare*—as the satisfaction of preferences, goals and ambitions, or the fulfilment of some sort of agreeable quality of conscious life (Dworkin, 1981a)—, the equality of *basic capabilities*—the abilities to do certain basic things (Sen, 1980)—, or the equality of *resources* (Dworkin, 1981b). It is also possible to expand the scope beyond egalitarianism, and justify reducing health inequities, for instance, on grounds of *utilitarianism* as it benefits the overall utility, either because inequities affect everyone or because interventions to reduce health inequities within a population are cost-effective (Beauchamp & Childress, 2001; Woodward & Kawachi, 2000).

‘What are you waiting for? You're faster than this.

Don't *think* you are, *know* you are’.

Morpheus (The Matrix)

3.3. Can Rawls’ account justify seeking to reduce health inequalities?

I said previously that Daniels aims at extending Rawls’ theory of justice to justify our moral concern about the distribution of health. Nevertheless, we should be aware that Rawls’ purpose is not to provide a moral justification to decide which goods are to be distributed under the rule of the principles of justice. Instead, Rawls proposes such principles for assessing and ‘choosing among the various social arrangements which determine this division of advantages and for underwriting an agreement on the proper distributive shares’ (Rawls, 1971 p.4).

Rawls claims the ‘priority of justice’ to any conception of the good. As a political conception—not religious, not philosophical, not moral—Rawls’ *Justice as Fairness* cannot contain any *comprehensive* conception of the good (Rawls, 1985). Moreover, any possible conception of the good should be a ‘thin theory of good’ that does not challenge the priority of justice (Rawls, 1971 p.396). However, justice’s priority does not mean that the conception of the good is not important. On the contrary, for the theory of *Justice as Fairness* the conceptions of good that people as citizens can pursue are significant. ‘Priority of justice’ means that justice sets beforehand the limits of the shared space such conceptions of the good will develop. A shared idea of the good is only possible for political purposes, and this must avoid any particular comprehensive doctrine as its foundation (Rawls, 1988).

The possible conceptions of good allowed by the Theory of Justice as Fairness include the idea of *Goodness as Rationality*—which Rawls takes for granted in any political conception of justice. Such an idea 'must count human life and the fulfilment of basic human needs and purposes as in general good' (Rawls, 1988 p.254). Goodness as rationality gives the framework for the account of *primary goods,* which are 'things that citizens need *as* free and equal persons' (p.257). This account aims at defining the kind of claims the citizen can make, and the framework for assessing and supporting those claims.

Health would seem to fit within the idea of a primary good in Rawls' theory; however, it was not included in *his* list of primary goods. The reason for this is that health is a good not completely under the control of basic structures; so, it cannot be included on the list of primary goods. The list of primary goods aims at having a 'practicable public basis of interpersonal comparisons' (Rawls, 1993 p.181), to evaluate the best social arrangement under the principles of justice as fairness; so such a list is not the end of the social arrangement, but a means to deciding among alternative social arrangements.

Independently of the reasons Rawls had for ruling out health, we should admit that —under the assumptions of the idea of goodness as rationality— any particular conception of good ought to recognize health as a human basic need. If this were true, health needs would be not only appropriate claims to weight under the terms of a liberal social agreement, but also constitute part of the idea of goodness that any political conception of justice contains.

Any (liberal) political system, as far as it promotes the fulfilment of basic human needs, should recognize health as a good to fulfil. The importance of protecting health as a good that any rational being pursues does not necessarily imply that there is a duty to *equalize* health between all individuals. Effectively, any political conception ought to agree on pursuing the health of citizens, as a rational duty of the political system —as is the case, for instance, of the utilitarian conception.

For if we agree that the basic structures influence health by means of what we now call the social determinants of health, then health is only indirectly linked to Rawls' principles of justice, insofar as these principles apply only to the basic social structures, and such structures are not completely responsible for health distribution. This idea is also present when Daniels says, 'health inequality is an inequity if it is the result of an unjust distribution of the socially controllable factors affecting population health and its distribution' (Daniels, 2008 p.101). A just distribution of the social determinants of health —according to Daniels— would and should be regulated under Rawls' principles of justice as fairness. The residual inequalities, those emerging even when social determinants satisfy the principles of justice as fairness, are acceptable as just.

Now, consider that Peter was right when she says, 'If the basic structure is just, then all outcomes these institutions produce can be considered as just' (Peter, 2001 p102). Also consider there were other goods whose distribution represents more truthfully the fair functioning of basic structures of society (in fact there are such goods—income distribution, for instance). Does this mean that it is the distribution of social determinants, not the distribution of health, which should be the focus of justice as fairness? Or should we stop being concerned about health distribution, and focus only on the goods that represent better the functioning social arrangement? My answer is no to both questions. We should keep our moral concern about health distribution, not because a just health distribution represents a just social arrangement or that it is important for equalizing opportunities. Our concern about a just distribution of health derives from recognizing health as part of the good everybody in a just society must be allowed to pursue and fairly realise.

We can conclude this part by agreeing with Daniels about the idea that Rawls' *Theory of Justice* can justify seeking to reduce health inequalities, but do so from a different approach. Health's importance surpasses the idea of protection of the *normal range* of opportunities open to individuals, because health is not only an instrument for individuals' pursuit of their own good, but is also part of this good itself; a good that any social arrangement should aim at fulfilling. Founding our concern about health distribution upon the recognition of health as a human basic need is a better way to justify actions seeking to reduce health inequalities.

3.4. The requirement of a conception of good

Up to now, I have argued that inequalities in health are a matter of justice; therefore, there is a moral duty to alleviate such inequalities. However, an account to justify actions seeking to reduce health inequalities should consider the concept of justice in a broader and more comprehensive sense than usual. Such a concept must embrace the possibility of change from a just arrangement to a more equitable one, through the inclusion of other values such as solidarity and beneficence as part of the concept. In this way, pursuing an equitable health distribution includes the reduction of inequalities deemed unjust as well as those considered non-inequitable inequalities.

I also argued that any political conception of justice ought to agree on the concern about the health of citizens as a rational duty of the political system, as far as such conceptions should count the fulfilment of basic human needs—including health— as part of the general good to be pursued.

In the same way, I want to suggest now that any political conception of justice would be unable to account for what the fulfilment of health needs means—at least, if we agree with Rawls about the impossibility of a just social arrangement that contains a comprehensive idea of the good. On the contrary, if we agree—and I certainly do— with the idea of health as some kind of state related to the wellbeing of a person and not only the absence of disease, and this state is part of the general good any political system should pursue; then, a just distribution of health has much more to do with the fulfilment of health needs than with the procedure of such distribution—even if all the social determinants of health could be controlled by a fair social arrangement.

In other words, the justification of aiming to reduce health inequalities requires a conception of justice broad enough to include the idea of what a good society wants for the people who live within it, and what this good means in terms of health. This seems like an idea that timidly emerges when Daniels suggests the use of a *thinner* veil of ignorance when selecting (fair) principles to govern health-care resource-allocation decisions, because we must know some features of the society, like resource limitations (Daniels, 2008 p.61). The idea of a thinner veil of ignorance openly departs from Rawls' original theory. On this, the veil of ignorance was conceived as a central constrain to 'nullify the effects of specific contingencies' (Rawls, 1971 p.136) making it possible to construct 'the unanimous choice of a particular conception of justice' (p.140). On the contrary, what Daniels is inviting us to do is to let the specific contingencies interfere with the selection of such principles.

Is it wrong to 'thin' the veil of ignorance in the way Daniel suggests? I think it is not. What this idea demonstrates is that complete ignorance about the way that the society values the goods at stake when choosing the principles for the institutions is what is wrong—at least when dealing with more concrete situations. To explain this conclusion we should remember that what Daniel implies is that we require the knowledge of society's resources to provide fair equality of opportunities, and this would require a lower level of abstraction as part of the veil of ignorance. Additionally, Daniels states that the defence of this device depends on the underlying theory of the person, which in this case should not be persons defined by a particular set of interests, but free and equal moral agents who may revise their life plans (2008 p.61).

If we were to agree to apply a less abstract veil of ignorance when we deal with more concrete situations such as the principles to govern health-care resource-allocation decisions, we could apply the same criteria in setting an account to justify seeking to reduce health inequalities. In such a case we might find two relevant issues behind the veil. First, knowing the resources available for health related decisions is just part of the information required, because we also need to know the magnitude of the problem—either inequalities of opportunities (for Daniels) or inequalities in health (in general). There is a significant difference between having a limited amount of resource when inequalities are huge than when they are small.

The second issue is certainly more contentious; it is to know what means 'health' for the institution whose principles we are to define. Again, the answers will be very different if health is understood as only related to the absence of medical conditions or as a complete state of wellbeing (WHO, 1946). But even if it is not possible to agree to a specific definition of health, at least there is an agreement—as we said before—on understanding health as a basic human need whose fulfilment is part of the general good any social agreement should pursue. If this were true, what we have is the requirement of such a thinner veil that allows knowing what 'good' means for society. Only if this were the case, it would be really possible to define the set of principles for equitable decisions seeking to reduce health inequalities.

Finally, we can so far conclude that health inequalities represent inequalities of the good a society pursues for the people who live within it, and this is why justice justifies seeking a reduction in such inequalities. To do so, justice must be a broader concept that justifies the change to a more equitable state of affairs and is sustained by a conception intimately linked to the conception of good.

Part II: A Justice Account to Inform Health Policies

4. Which concept of justice?

My argument from the previous chapter can be resumed as follows: there are some inequalities in health that qualify as inequities and other inequalities that do not. Inequalities that qualify as inequities are those that can be deemed to be unjust or rooted from some form of injustice, so it is clear that it is justice which justifies reducing such inequalities. Conversely, inequalities in health that do not qualify as inequities are, for instance, those that represent unequal outcomes in health due either to biological variations or to free chosen behaviours. It is reasonable to conceive that it is morally justifiable to seek to reduce some of these inequalities, but such a moral justification is usually ascribed to other principles such as beneficence or solidarity.

However, a problem emerges when it is required to decide among competing courses of action, for example in allocating resources, and it entails choosing either the justice-backed course (to reduce some health inequity) or the beneficence/solidarity-backed one (to reduce an inequality not deemed inequity). As to solve this problem, i.e. if allocating resources to reduce inequities or to reduce not-inequities, requires itself an account of justice, I concluded that it is justice what justifies reducing both inequities and not-inequities.

In other words, I argued that aiming at reducing health inequalities is grounded on justice, and this must not be understood only in the 'negative' sense that derives in reducing health inequalities that are deemed unjust, i.e. those that constitute health inequities. On the contrary, justice is the right foundation to explain why we decide to go further reducing health inequalities—even though they do not constitute inequities. This sort of ‘positive’ sense of justice requires a more comprehensive concept of justice able to account also for beneficence, solidarity and the like. This is the subject matter of the present chapter.

4.1. The concept and the conceptions of Justice

It has been said that the concept of justice could be fulfilled by various alternative conceptions, so the *concept* is what is generally agreed about the ‘idea’—i.e. the object of our understanding (Locke, 1975)—of what justice is, whereas the *conception* represents a less abstract level of the idea of justice which contains its specifications and may take various and sometimes conflicting forms (Dworkin, 1977 pp.134-6). If I were to follow this classical distinction, perhaps I should say that what I am searching is a *conception* of justice comprehensive enough. Nevertheless, I said before that what I require is a comprehensive *concept* of justice, so I must begin by clarifying why I prefer using ‘concept’ instead of ‘conception’. The importance of this is firstly trying to leave behind this, in my opinion, rather confusing divide between concept and conception of justice; and secondly, facilitating the task of extending the boundaries of our understanding of justice that I see constrained by this distinction.

For instance, Rawls conceived the *concept* of justice as the (first) *virtue* of social institutions by which, on one hand, such institutions do not make arbitrary distinctions between persons when assigning basic rights and duties, and, on the other hand, social rules determine a proper balance between competing claims to the advantages of social life. Such a concept remains open to competing ideas of what will differentiate an arbitrary from a non-arbitrary distinction, and what will determine the properness of a determined balance between claims. Rawls proposed that a set of principles—the 'Principles of Justice'— is required to fill in this gap. Such principles define the basic terms of the social agreement, so they are to be accepted by all that have their particular conceptions about what is required in determining the division of advantages and the proper distribution of shares. Therefore, the object of the agreement is a 'shared' *conception* of justice specified by the Principles of Justice. (Rawls, 1971 pp.3-6).

However, what Rawls takes for granted as *the* concept of justice is not the only formulation of a concept of justice that has been proposed; there are alternative formulae intending to fulfil a more general and abstract idea of what justice is. For instance, if we are to consider the concept of justice as 'treating like cases as like, and different cases differently', what we are to fill in —i.e. what is to be settled as the conception of justice— is the specific idea regarding the relevant similarities and differences that make the cases alike or not alike. In these terms, what Rawls refers to as a 'concept' of justice would be just one alternative 'conception' of justice (Waldron, 2003 p.270). Therefore, what we refer as a Rawlsian conception of justice is not only the principles Rawls arrived at, but the whole idea of justice as a virtue of principled social institutions. (It may be said, for example, as an alternative conception to Rawls', that justice is an *individual's* virtue).

To understand the divide between concept/conception which now may appear hard to follow, it is possible to say, as H.L.A. Hart does, that the idea of justice has a structure consisting in two parts: a constant part —'Treat like cases alike'— and a varying part which establishes the criterion to use in determining when cases are alike or different (Hart, 1963 p.viii; 1994 p.160;). Nonetheless, this seems to be reducing the idea of Justice to the result of a formula like the following one (being J: Justice, K: a constant ('treat like cases alike') and α: a variable part):

$$J = K + \alpha$$

In this way, the 'concept'—as a more abstract idea of what is justice— would be equivalent to the constant part; meanwhile, the 'conception' would include both the constant and the variable parts. Seen in this way, the concept of justice is necessarily incomplete, and it follows that the more abstract idea of justice risks to be useless; that is to say, it might be more difficult to find out a more useful idea of justice if it were not concretely specified (Dworkin, 1998 p74). Thus, thinking about justice as this 'two part structure' leads more to look after the specifications of justice—the task of setting α— than to the idea of justice itself (which should be the case when different theories of justice are at stake).

Moreover, if the debate about alternative accounts of justice requires a certain level of specification to make them 'useful'—for the purpose of guiding our decisions— then, such a level of specification entails a proportional level of restraint through the use of a determined conception of justice. That is the case of, for example, Rawls's conception of justice —'justice as fairness'—which is intended as a conception that applies only to political institutions of constitutional democracies (Rawls, 1985).

Nevertheless, there is an alternative approach to understanding the compound structure of the idea of justice proposed by Hart. It is that the constant element of the idea of justice is its *formal* part, and the varying element is its *material* part (Hart, 1963 p.vii). Derived from this, the formula 'treat like cases as like, and different cases differently' is often labeled as the 'formal principle of justice' (Buchanan & Mathieu, 1986 p.15).[7] Interestedly, it has also been said that, for Aristotle, justice is a concept compounded of a formal part, and a material part (Hart, 1963 p.vii). So, in Aristotelian terms, it should be said that justice is a *hylomorphic* compound. The important thing that I want to rescue from this proposition is that *hylomorphic* compounds are 'produced' when the form is put into the matter (Aristotle, 2008 Z.8, 1033a30-b9). If this were the case, the concept of justice should be understood as a thing that is a *result* that is produced.

Suppose now that we name the process of producing a concept as a 'process of conceiving' —which is the meaning of *conceptio,* the Latin root of the word 'conception' (Merriam Webster, 2009). In that case, the outcome of such a 'process of conceiving' should be a *conceptum* —the Latin root of the word 'concept'—which means 'that which is conceived'. Following this rationale, we might draw the conclusion that different conceptions of justice are neither 'more concrete' alternatives to represent the 'more abstract' concept of justice, nor alternative 'complements' for the concept of justice, but alternative ways of 'producing' (conceiving) the concept of justice.

If justice is seen in this way, it becomes clearer why alternative 'conceptions' of justice look like stemmed in alternative 'concepts' of justice. For instance, the concept of justice that utilitarians have in mind when they think that it is just to take a property without an

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[7] Such a principle is said to emerge in Aristotle's work, specifically in Ethics '[…] there will be the same equality between the shares as between the persons, since the ratio between the shares will be equal to the ratio between the persons; for if the persons are not equal, they will not have equal shares[…]'. (Aristotle, 1934: V.iii.6), and in Politics '[...] those who are by nature equals must have the same natural right and worth, and that for unequals to have an equal share[...]' (Aristotle 2004: III, c16§2),

owner’s consent if this contribute to the greatest sum of happiness seems to be exactly the opposite to the concept that libertarians have in mind as they think that it is unjust to take a property without an owner’s consent. The conclusion might be that appealing to a divide between a concept and conceptions of justice is worthless when it is taken into account that the resulting (concept) of such process of conceiving (conception) justice will depend not only upon what are the concrete specifications of justice but also in how the process is carried out.

Such a process of conceiving justice will in turn depend on which I might call ‘accidental elements’, i.e. those elements that give the essence its actual form, such as the subjects it applies to, or the culture or believes prevailing in a determined place or time. In doing so, what I want to recognize is the fact that the concept of justice encloses the idea of movement.

4.2. The concept of Justice as an action

As the *form*, according to Aristotle, is the ‘essence of each thing, and its primary substance’ (Aristotle, 2008:1032b1), it is possible to derive a second conclusion from the idea of justice as a hylomorphic compound; this is that the *concept* of justice is *essentially* its form. If we were to take, for instance, ‘treat like cases as like, and different cases differently’ as justice’s *form*, then we could say that the concept of justice has *essentially* the form of an *action*. We could obtain a similar conclusion if we were to use an alternative formal idea for justice, such as the one Plato attributed to Simonides ‘to give what is owed to each is justice’ (Plato & Griffith, 2003 p.5). In other words, in both cases justice, as a concept, might be considered the result of an action—as it is conceived—, but simultaneously an action itself, for it has *the form of an action*.

Nevertheless, it is more frequent to find justice considered as a *virtue* rather than as an *action*. As I mentioned before, for example, Rawls' concept of justice is that it is the (first) virtue of social institutions; and this is a widespread idea that is present since Aristotle's *Politics* '[...] justice has been acknowledged by us to be a social *virtue* [...]' (Aristotle, 1905 III.xiii.3).

I must go into discussing justice as a virtue in depth later, for what I must do first is to explore the idea of justice as action, and then explore how 'justice as an action' can be related to 'justice as a virtue'. For doing so, I would like to use Pogge's taxonomy of the concept of justice (Pogge, 2004 pp.141-145), though in a different way than he does. According to him, the concept of justice is a 'predicate'—i.e. it is something 'said' about something else. It is possible to apply it to four kinds of 'subjects'[8]: to *persons* (individuals or groups), to *conducts* (acts or omissions), to *social rules*, and to other *states of affairs*. For these potential subjects, the concept of justice can function as a one-, two-, three- or four- places predicate. The first case, refers to justice when said about one subject (any of the above mentioned); however 'just' is more often said about one subject A *towards* a recipient B (two-places predicate), and it is even more frequently said that A is just (or unjust) towards B *regarding* C (three-places predicate) —the latter being the one Pogge considers the more fundamental use. However, he adds a fourth place D—which he calls the *agent*— who has or shares the *moral responsibility* for the justice or injustice of the

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[8] Pogge uses the word *judicandum* to refer to what is said to be just or unjust; however this might be confusing, even though his translation of the word as 'that which is to be judged' might be deemed right; for this word applies primarily to the person who faces a trial, not the judge in the trial. The judge can be said just or unjust when become a judicandum under trial, but then he is not acting as judge. To avoid this potential source of confusion, I replaced the word judicandum for 'subject' which Pogge uses regarding to persons and groups, but I intend to use as 'that of which a quality, attribute, or relation may be affirmed or in which it may inhere' (Merriam-Webster) —i.e. that of which 'just' might be predicated.

subject. This allows him to differentiate a *passive* concept of justice —the three-places predicate— which emphasizes the recipient's point of view, from an *active* concept of justice —the four-places predicate— which emphasizes the agent's point of view. Interestedly, what Pogge aims to do is to move away from the idea that the concern of justice is 'simply' related to the impact for the recipients—'to be just is to promote a good distribution' (p.146) — to the concern about the relation between agent(s) and recipient(s) —'to be just is to give equitable treatment' (p.146).

Drawing upon Pogge's ideas outlined above, it is possible to say firstly that implicit in the idea of A being just towards B regarding C is that there is an act (either action or omission) of A towards B; and this is exemplified in the use of verbs such as 'to promote' (a good distribution), or 'to treat' (equitably the recipients). By adding D to his account of the concept of justice Pogge is emphasizing the relevance of acts where there is an agent who is morally responsible for such an act. Through this, what he is making relevant is not only the relational character of justice, but also the important role of the agent when the act which relates A towards B regarding C, is to be assessed as just or unjust.

It is important to note that in Pogge's account, an agent is whoever holds or shares moral responsibility in the way A relates to B regarding C. This adds an important level of complexity to the analysis by extending the assessment of justice to include all relevant share-holders of responsibility. So, when we assert that the consequences of Katrina were unjust, we make a claim in relation to the Government's responsibility to prevent the consequences, not because Katrina acted unjustly. However, if we were to recognize that what relates A to B has the *form* of an action, whatever the action, there is always something or someone who performs such an action. As in its more general use, 'agent' refers to ‘something that produces or is capable of producing an effect’ (Merriam-Webster 2009); we might regard that as A produces or is capable of producing an effect toward B regarding C— thus, we should count A as an agent. Nevertheless, even though A produces or is capable of producing an effect toward B regarding C, this does not necessarily imply that A is ‘morally responsible’ for such action; for it is possible to split the responsibility for *producing* an effect from the moral significance we are assigning to the responsibility to *address* the consequences. In our example of hurricane Katrina, we might say that Katrina is responsible for the effects it caused to New Orleans’ citizens, but it is absurd to say that it is *morally* responsibly. However, as I said before, we could still say that the consequences of Katrina were unjust; but we do this *because* there is a Government to who we attribute the moral responsibility for preventing the hurricane’s consequences. Such consequences for New Orleans’ citizens thus are not the outcome of the single action of the hurricane blowing over the city, but are also the effect of the omissions in preventing the possible damage from hurricanes.

Thus, what is important to take from Pogge’s account is the need to identify the morally relevant action and thereby its agent. For the outcomes of Katrina the action of blowing winds is not the relevant action, but the actions (or omissions) of Government in the *circumstances* of Katrina. Therefore, the judgement is not about the relationship of Katrina as A towards B, but Government as A towards B (New Orleans’ citizens). Therefore, through the analysis just outlined we finally arrive at the idea that justice is something that we can predicate about different subjects; however it is primarily predicated upon the *morally relevant actions that relate a morally responsible agent with the recipient(s), or affected by, such an action*.

In saying that Justice is ‘primarily’ predicated upon actions, I mean that when we predicate justice upon subjects such as persons, social rules, or states of affairs, we are making reference—either implicitly or explicitly—to an actual or potential action involved. For it seems absurd to deem unjust a state of affairs that is neither the consequence, nor can be modified by the action of some morally responsible agent; similarly, one cannot deem a person unjust if it is not *qua* moral agent, i.e. someone who carries out an action which is susceptible to be deemed unjust. Moreover in the case of social rules, insofar they are intended to set the boundaries for the actions carried out by those who belong to the society that bears such rules.

Note, however, that I am not implying that a judgment about how to deem the other subjects will depend of how the action related is deemed. I propose, instead, that the concept of justice rests upon the relations underlying actions upon which one may predicate justice.

4.3. Justice predicated upon the moral agent: The concept of Justice as a virtue

Thus, if predicating justice about the action involved not necessarily implies the way justice is predicated about the agent or the resulting state of affairs, we need to extend the concept of Justice as an action to account for these other subjects.

Following our argument—that we can predicate that the moral agent A is just or unjust towards B regarding C—suppose that our moral agent is a teacher A that is marking the students’ essays, and he underscores B’s essay because B misbehaved during A’s lectures. We might deem this as an unjust action of A towards B regarding the essay’s mark. Moreover, we could deem the teacher as unjust according to this action, as B probably does after learning his mark. However, a further analysis of the way this teacher mark students' essays reveals that he almost always marks only according to the quality of the essays. Can we sustain still that teacher A *is* unjust? Or, it was only a circumstantial failure of his otherwise *being* just? To give an answer to such questions requires us to respond a previous one: what are we saying when we say that an agent *is* just or unjust?

As I see it, to say that someone is just is to say that he or she *habitually* carries out certain kind of actions—which constitutes a *practice*— that are deemed as just. And saying so, it is a *virtue* what we are attributing to him or to her. As practice provides the ground where virtue is exhibited (MacIntyre, 2007 p.187), the practice of just actions is indeed the way the virtue of justice is manifested. Certainly, it is possible to say that the practice of just actions does not necessarily is the expression of having the virtue of justice; and, in so saying, probably I require giving an account of what virtue is—for virtue is itself a contested concept. Moreover, if we are to extend the concept of justice to include its use as a predicate for actions as well as for moral agents, it seems to me that it is unavoidable to give some account of virtue.

I shall begin by claiming that a virtue is a good quality of moral agents; by saying so, I mean that is something predicated of somebody that entails a positive moral value. I will not give an account for such a positive moral value here; so, let us accept for now that, at least, no virtue is regarded as an evil in any ethical theory.

Secondly, this quality is related to action, but not to an action in particular but to a systematically repeated action, i.e. to a kind of activity or practice. This claim is retrieving

Aristotle again, who supported the idea that, roughly speaking, a virtue is formed as result of engaging in the corresponding activity[9] (Aristotle, 1934 II.i.7).

Focusing in justice as a virtue Aristotle claims that 'we become just by doing just acts' (II.i.5). However, this relationship functions in the opposite sense, as well. For the virtue is exercised in full through just actions (II.ii.8); thus, whereas justice is formed through just acts, just acts are done *because* of justice. According to this two-ways relationship we might claim that the virtue of justice is either the resulting 'habit'—as the settled tendency or usual manner of behaviour (Merriam Webster, 2009)— of doing just acts, or the 'principle' —as underlying faculty or endowment (Merriam Webster 2009)—which makes us to do just acts. For instance, if we were to apply the claim that the virtue of justice is either the resulting 'habit' or the 'principle' which makes us to do just acts to Rawls' concept of justice, it should be said that justice is either the 'habit' of social institutions of doing just acts or the 'principle' which makes social institutions to act justly.

Nevertheless, although the virtue of justice might be stated either as a habit or as a principle, what specifically is said is a contentious issue; for example, whether it consists on (a) having the *disposition* to act following the rules (of justice); or (b) having the *ability* to perform actions in a way that the resulting outcome is a state of affairs that can be deemed just; or having either (c) the *disposition* to act as a virtuously just agent would act in the same circumstances (acting *from virtue*), or (d)the *ability* to act in the way a

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[9] Note that Aristotle is here referring to 'moral' virtues in opposition to 'intellectual' virtues which are not the product of activities but produced and increased by instruction (II.i.1). Insofar our interest is centred in justice which Aristotle counts as a 'moral' virtue, and not in developing a theory of virtues in general, we are taking only the moral virtues into account.

virtuously just agent would act given the same circumstances (acting *virtuously*)[10][11]. Bearing this in mind, let us use Rawls concept of virtue as a proxy to develop a more detailed account of virtue.

Firstly, Rawls defines virtues as 'sentiments, that is, related families of dispositions and propensities regulated by a higher-order desire'(Rawls, 1971 p.192) which in this case is the desire to act from the moral principle of right and justice (p.436). Secondly, Rawls claims that 'the virtues are excellences' (p.445), that is to say 'characteristics and abilities of the person that it is rational for everyone (including ourselves) to want us to have..., the excellences are goods since they enable us to carry out a more satisfying plan of life enhancing our sense of mastery' (p.443). Finally, Rawls encloses the virtue of justice into the psychological sphere, equating the virtue of justice with the *sense of justice* (p.479f). These three main ideas lead us, on one hand, to question if justice is appropriately stated as a virtue of social institutions, or at least to question if social institutions can possess a (psychological) sense of justice. On the other hand, the reduction of virtue to psychological trait detaches virtues from the good they might have themselves, leaving just the utility they produce through the disposition to obey the rules of morality—something that Rawls shares with Hume, Kant and Mill (MacIntyre, 2007 pp.232-3)—that are to be set beforehand in an 'original position', and the persons behind the 'veil of ignorance' who set the rules must have 'certain psychology' (Rawls, 1971 p.121). Such psychology implies that they are capable of a 'sense of justice', which means that they 'can rely on each other to understand and to act in accordance with whatever principles

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[10] More discussion about this: (Driver, 1996)

[11] On the distinction between acting from virtue and acting virtuously see (Swanton, 2001).

are finally agreed...their capacity for a sense of justice insures that the principles chosen will be respected' (p.145).

Rawls' account seems to correspond to the alternative (a) stated above regarding what the virtue of justice consists on: having the *disposition* to act following the rules (of justice). Such a disposition cannot, in this case, be taken as a synonym of *habit*, for Rawls is aiming at detaching justice as the resulting quality of a usual manner of behaviour from the justice as a *principle* according to which one perform just actions. This, I think, is because he thinks that it is only possible that a specific settled manner of acting might be deemed just if and only if it is performed according to the rules constitutive of the principle(s) of justice previously determined by people who possess the specific disposition to follow such rules; so that, such a specific settled manner of acting could not perfect the disposition in the original position without breaking down the idea that the virtue of justice is the disposition required in the original position. On this, Rawls' account of Justice as a virtue can be counted as an example of a Kantian account of virtues, as the disposition above mentioned can be read as a trait of the goodness of an agent's character who has internalized the capacity to test the universalizability of his/her maxims (Oakley, 1996), if we are to take the principles of justice as maxims for actions of social institutions aimed at distributing basic rights and duties.

Similarly, the emphasis that Rawls' account puts on the 'principle(s)' of justice dismisses unnecessarily the importance that training and experience has in the development of virtue. To give an example of its importance, suppose a judge of the Supreme Court that has to decide about a very complex case for which there is no jurisprudence; it is not only that we value her ability to follow the rules of Law, or her impartiality, or even her ability to decide putting herself in an ‘original position’ standpoint, for all those things could be perfectly the qualities of a good citizen; however we name her quality to decide in such a case as ‘virtue of justice’ *because* we recognize in saying so a quality that is not given by a psychological disposition but by the experience acquired through a certain practice of just actions that is exceptional among citizen; a *knowledge* learned not only in the theory but also in the practice. Paraphrasing Morpheus quoted at the beginning of this section —it is not her *thinking* of being just that matters but her *knowing* of being just. In other words, those who know how to be just do not need to think how to be just.

On the other hand, a concept of the virtue of justice stated as in (b) above—‘having the *ability* to perform actions in a way that the resulting outcome is a state of affairs that can be deemed just’—would require, instead, introducing an evaluative account of the consequences of the actions commanded by the virtue of justice; and this could be said to represent a consequentialist concept of the virtue insofar it would be the consequences of the actions what determines whether the agent is just or not. Certainly, as Mill put it from the point of view of utilitarianism—as a form of consequentialism— ‘a right action does not necessarily indicate a virtuous character’ (Mill, 1991 p.152), adding that considerations about the goodness of the agent are not relevant for estimation of actions, but of persons (p.151); so it might seems that virtues in such an account do not matter. However, forced to deem an agent as just or unjust, a utilitarian would need to appeal to the quality of been able to obtain just consequences from actions, i.e. to do just actions.

The contrast between (a) and (b) regarding justice as a virtue become more clear if we think that a concept of Justice stated as the virtue of (only) having the disposition to act following the rules excludes the possibility of including as part of such a virtue the quality of moral agents to go beyond the boundaries of the set of rules or even override such rules in pursuing a good. For instance, in such account the quality of a free rider who contributes to maximize the total utility by regularly not following the rules would never be named virtue; but for some utilitarian such a quality *is* a virtue. This does not imply that utilitarianism is right regarding what the virtue of justice is, but at least brings attention over the necessity of further discussion about the relationship between justice as a virtue and the goodness of the state of affairs resulting from such a virtue. And this not only refers to the problem of A being deemed just or not insofar is doing something that can be judged as *good for* B, but also whether A's acting towards B should be *good for* A or not to be deemed as just; or even whether such an action must be good for the practice involved to judge A as being just.

4.4. Justice as a State of Affairs

From a utilitarian point of view, what counts as a virtue thus is derivative from the state of affairs that is consequence of A's action towards B, so that such action contributes to the overall good. In this case it does not matter if the consequences of 'being virtuous' are good or not for A; in other words, a just A makes just actions towards B probed in turn that such actions contribute to the good for all B even if it is not good for A himself (Mill, 1991 p.141). Nevertheless, as I see it, this presents at least two problems for a concept of justice that accounts for justice as a virtue. Firstly, it is contentious whether it is right not to count the motives and intentions for acting on a just way as part of the virtue of justice—a problem common to any consequentialist account; for someone who is known to be acting in such a way that its consequences produce just states of affairs might be motivated by looking after honours for himself and not by intending justice, hardly could be deemed as having the virtue of justice. Secondly, it is also contentious the requirement of A's neutrality for evaluating the consequences of his/her actions towards B, so that some action directed to a specific recipient must be weighed against the overall good produced, counting this recipient as one more of the whole recipients of the consequences of my actions. Thus, someone who shows preference for his own family even if with his action is actually diminishing the overall utility could not be regarded as having the virtue of justice which contrast with common sense of justice as giving something that is due. Sidgwick point it out in the same direction when states that the notions of Desert and Fitness conflict, as the latter —that he regards as a utilitarian principle of justice—limits the realization of what is the chief element of Ideal Justice: the Requital of Desert (Sidgwick, 1981 p.283); in other words, differentiating between a B who deserves the good produced by A's actions and the whole that could benefit from an alternative course of action should be counted as part of the virtue of justice, even if this does not contribute to the overall utility.

Nonetheless, it is not how consequentialism could account for justice as a virtue what is more problematic, but the fact that the only good that counts for such a virtue is the good for B (or the sum of all possible B); and as we said at the end of the previous section, it is also important to consider whether A's acting towards B should be *good for* A; and whether such acting must be good for the practice involved.

Opposed to the consequentialist point of view we might find those accounts of 'virtue ethics'. As Oakley puts it (1996), virtue ethics bases its criterion of virtue not in the agent's capacity to test the universalisability of maxims or its disposition to maximize goodness, but in the goodness the virtue represents *for* the agent, which can be understood from either an eudemonistic point of view (the virtue is good for the agent to live a happy life); a perfectionist point of view (the virtue is good for the agent as it represents his/her essential properties as human beings); or an admiration-based point of view (the virtue is good for the agent as it represents traits we commonly find admirable).

I will not discuss the differences between alternative ideas of the *good for the agent* that virtue represents; for, although these are important to distinguish among the several virtue ethics accounts, I think at this point it is more relevant to discuss how these are to account for the relationship between justice as a virtue and justice as an action. In relation to this, we can distinguish the alternatives (c) and (d) mentioned before, where justice as a virtue is respectively either the *disposition* to act as a virtuously just agent would act (in the same circumstances), or the *ability* (or *capacity*) to act in the way a virtuously just agent would act given the same circumstances. In both formulations the key factor of the virtue is the character of the agent, so that we can say that both represent 'virtue ethical approaches'; however, the distinction between them is given by their different approach to the realization of justice through the action the virtue originates, so that the former could be labelled as 'acting *from the virtue*' and the latter as 'acting *virtuously'*.

Thus, if justice is a disposition to act *from* the virtue of justice—i.e. disposing oneself by the practical wisdom (*phronesis*) to act as a virtuously just agent would act in the same circumstances— justice in the action and the resulting state of affairs will depend on how we deem such a disposition. Therefore, the outcome is important as far it is what a virtuous agent would intend according to his/her practical reason —'the target' according to Swanton (2001)—i.e. the *potential* outcome. If the outcome is not the expected, i.e. it is not *actualized*—for example, due to external contingencies—this does not affect the fact that the outcome resulting from such an action—performed from the disposition to act as a virtuously just agent would act—should be deemed as just. This certainly recall Kant, in the sense that moral goodness only appears after having verified that the maxim of action can be made universal (Gonzalez, 2008); so that in this case justice will appear after verified a maxim which can be recognized universally as part of the virtue of justice. This is exemplified in Foot (Foot, 1985), who states that 'justice is primarily concerned with the following of certain rules of fairness and honest dealing and with respecting prohibitions on interference with others rather with attachment to any end'.

The alternative (d), *acting virtuously*, is more exigent regarding both the agent, and the resulting state of affairs—as it adds the necessity in the agent of developing the virtue of *expediency* (or *effectiveness)* as part of the virtue of justice, aside of the practical wisdom; for what is meant by *acting virtuously*, is having not only the disposition to act according to what is seen as the way a virtuous agent would act in a given circumstances, but also the ability to act in a way that the outcome is one that can be deemed as just independently of knowing or not the fact that the agent is actually virtuous. This alternative seems to me to be closer to an Aristotelian account of virtue; firstly, for he stated that the first motive of practical reason is *realisable* good (Aristotle, 1986 III,10), so that disposing oneself to act according to, for instance, certain rules of action that I know I am not able to realise should not be counted as a virtuous disposition. Secondly, as we mentioned above, for Aristotle 'we become just by doing just acts'; so that the outcomes of our actions can be considered just, even if we are 'in the way' to become virtuous; and this means for the virtue of justice, that it is in the *doing*—the realization just actions—

that the virtue is complete, and therefore, we can deem the agent as just. Additionally, this has much more to do with the understanding of virtues as realised through the *practice*, for is attending to the outcome that we can perfect our practices and become excellent in their execution, i.e. become virtuous.

The alternative (d) is, therefore, the concept of the justice as a virtue that I will use in completing a more comprehensive concept of justice; although, to complete such a concept of, it is necessary to bring up the moral relevance of B and C under the scope of this enquiry. For the state of affairs produced by A's action refers to B regarding C, it is not the same whether B and C are morally relevant or not; in other words, it is not the same distributing food (say peanuts) to the squirrels in the park than distributing food to children in the school, in the same way that is not the same distributing sweets to the patients in an hospital than distributing medicines to them.

What I am now aiming at is to introduce the point of view of the recipient to give an account of what justice means; for it seems to me that if an action were deemed just from the point of view of the agent, but at the same time deemed unjust from the point of view of the recipient, then the concept of justice we were using would not be the correct one.

This could be stated in a different way: from justice emerges—for a morally relevant B—the *right* to certain outcome when A acts towards her in regarding to a morally relevant C. It can be said, for example, that the patients that did not receive their medicines because the pharmacist was unable to carry out an action whose resulting state of affairs were deemed as just *for* them —i.e. independently of pharmacist's having the disposition to act justly—, can raise the claim that, although they were treated *fairly*[12] by the pharmacist, their new state of affairs is not just, as they have the *right* to receive their treatment. Such rights, thus, are to be understood in this account as the expression of what the recipient *deserves* regarding the action performed by the agent, as well as the resulting state of affairs.

Therefore, it is clear that a concept of justice is not complete if it does not give an account of rights; however, I will turn to *rights* as part of this account of justice later, for I must firstly clarify the role of goodness in regarding justice; because, we might think after what was said previously, that A being deemed just means something *good for* A (a virtue) that requires that her having the virtue, and acting accordingly, should be also judged as *good for* B, and likewise, good for the practice involved.

4.5. Justice, Goodness and Beneficence

Different ethical accounts have different approaches to the relationship between good and just. For example, Aristotle would claim that just actions, as any other kind of actions, are carried out intending some good (Aristotle, 1934 NE:1094a1). On the other hand, Rawls—even though he aims at detaching justice from the good—recognises that justice is something that any rational account of goodness should include as a good (Rawls, 1988). According to Hursthouse (Hursthouse, 2006 p.100), a reductionist approach would say that deontology defines *the good* in terms of the *right,* whereas consequentialism

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[12] Here I use *fairly* meaning a deontological or non-consequentialist idea of justice; that is to say, following the rules of justice or disposing him/herself to follow such rules.

defines *the right* in terms of *the good*; and virtue ethics could be said defines both *the right* and *the good* in terms of *the virtue*—being the latter an impossible for Hursthouse.

Where is *the just*, then? H.L.A. Hart stated that 'just and unjust are more specific forms of moral criticism than good and bad or right and wrong'; (Hart 1994 p.158); following this, we could say that *the just*, is either a derivative from *the right*, or a derivative from *the good*, or even a derivative from both. As we are looking to delineate how justice and good are to be related, we could say now that there would be two possible strategies: either we derive *the just* from *the good* directly as we derive *the right* from *the good*, or we derive both *the good* and *the just* from *the right*; and it could be said that the former corresponds to a consequentialist approach, whereas the latter to a deontological one. Nevertheless, I think that both strategies are wrong as I agree with Hursthouse that such a kind of conclusions is too reductionist, for they treat to stand from a monistic concept from which all the other are to be derived; in the same way that I think that deriving *the just* from *the virtue* is wrong. The issue is much more complex; however, it is possible to advance that to extend the concept of justice we should take not a 'derivative' approach; instead, we should take one that captures such concepts as independent but interrelated.

Such a complexity is maybe better represented in tragic dilemmas—at least better than my previous example of the pharmacist—as the one put forward in *Sophie's choice* (Styron, 1992), where the protagonist was forced by a Nazi guard to decide which one of her children had to be killed and which one had to be saved, and if she does not decide both will be killed. Much might be said regarding to whether her decision was *the right* one or not, or whether her election maximized *the good* as she saved at least one from being killed, or even whether she acted as virtuous person would have acted in such a situation; however, no one of these will change the conclusion that the outcome is unjust for the recipients of her decision, for both children have *the right* to live.

It is not my objective to give a complete account of *rights*, but I have to point out that what I take for a right is, on the one hand, that that is owed by another, and on the other hand, the good to which a just action must intend; so that *a right* is to be understood as *the object of justice*, i.e. its realization. The problem that emerges with such a characterization is to elucidate what is the good that have to be intended; we might say that it is the good that is owed, but this answer falls into circularity. We might think that it is the good of overall utility as utilitarians do; but as we already mentioned, even Sidgwick recognizes that utility ('fitness') sometimes clash with what is just, and such an account hardly could recognise a right to something owed if utility mandates the contrary. A deontological account, in turn, falls apart from my characterization of rights, for in this account the acts of justice should not intend a good to be properly deemed as just, except for the good that derivates from acting according a universalized maxim.

To make my point clearer, let us consider Socrates' example of someone who borrowed a weapon from a friend who was perfectly sane but afterwards went mad and then asked for the weapons back (Plato, 1886, 331c). For a pure deontologist, giving back the weapon is the only possible alternative of action as maxims cannot accept exceptions, so that giving back the weapon is the right thing to do, and derivatively the just thing to do. In turn, a pure utilitarian would answer 'it depends' on how we are to count the contribution for the overall utility of each alternative (we could think, as some people do, that we can put him isolated to avoid harms for others, and then give him the weapon back if this makes him happier, for example).

However, I think that what we *naturally* do is to evaluate to what good each alternative is contributing, so that we might say that if we avoid giving back the weapon it will be good for his health and for the security of the people surrounding him—or as we usually say, their *right* to health and security— whereas giving back the weapon will be good, for instance, for his freedom—or his *right* to freedom. Here is where we need to understand justice as a virtue, for it is our practical wisdom and our ability—developed through the practice of just actions—to choose which good (*right*) has precedence and which one has not, what will enable us to decide and to perform the just action in such circumstances. I have to make clear that this does not mean that each one should act according to his/her experience, as if experience were only the way to get the knowledge about the goodness on the ends of the actions; on the contrary, what the experience does is to help the practical reason to grasp the good in things that is its proper object.

I must to recognize that I am standing closer to a *Natural Law* point of view of what is justice, of the kind found in Aquinas (Aquinas, 1947 II-IIae q57-58), which in turn roots on Aristotle's account of the virtue of justice (Aristotle 1934, V). On this account, there is no contradiction or separateness between Justice and Benevolence; as when it is said that 'the special function of Benevolence begins where Justice ends' (Sidgwick, 1981 p.242). On the contrary, following Aquinas we might say the distinction between both virtues corresponds to their 'formal object' (*formalis obiecti*) for the formal object of Benevolence is *the good* (Aquinas, 1947 IIª-IIae q31), whereas the formal object of Justice is *what is owed* (II-IIae q57-58). However, looking at the 'material object' (*materialis obiecti)*, which is the same—the act performed—we realise that the actualization of a virtuous act of justice must consider Benevolence as well as a virtuous act of benevolence must consider Justice; so that, nothing that is done intending the good of other can be unjust and nothing intending to render what is owed can be an evil for the other, as was made clear from Socrates' example. Seen from the point of view of Justice, thus, Benevolence is a virtue that perfects Justice.

It is worth to note that to 'facilitate' the understanding of the virtue of justice as a 'perfectible' virtue, Aristotle in *Ethics* (V.10) introduced the concept of 'Equity' (*Epieikeia)*, which is superior to justice but also the same that justice; so that, it is superior to the 'legal' justice but the same that 'ideal' or 'true' justice. He exemplifies Equity in the man that is not stickler for his rights—and tends to take less than his share though he has the law in his side— although he did not explain why doing so would be better than taking the complete share. Aquinas supplement this explanation using Socrates' example previously mentioned (II-IIae q120), saying that, as giving back the weapon would be cause of evil, not giving back the weapon is acting according to Equity; therefore, we can conclude that somebody that does not take his share is equitable iff this is intended for the good of others, although, in the same way we can conclude that someone who does not take his share and with this causes an evil to his family and benefit a rich man is not equitable.

Through the discussion exposed, I have arrived to a concept of justice that I now can spell out as 'the virtue of rendering each other the goods that are owed', in other words 'the virtue of rendering each other their rights'.

4.6. The role of community in defining the good we owe each other. The communitarian perspective

Communitarianism arose as a reaction to liberal theory, particularly - but not exclusively - as a critique of Rawls and his neocontractualism, which assumes that the primary task of governments is to secure and distribute fairly liberties and economic resources that individuals need to lead freely their lives (Bell, 2001).

Although there is a diversity of emphasis and nuance in the critiques of liberalism and the proposed alternatives, we can say that the main communitarian authors —Alasdair MacIntyre, Michael Sandel, Charles Taylor and Michael Walzer—have in common the place that they give to the good of the community as well as that of the individual, criticizing the human vision underpinning liberal thinkers, that insufficient attention is paid to the moral importance of the social fabric that binds human beings for their mutual benefit and care. Communitarians critique of liberalism also focuses on the liberal emphasis on individual rights without a corresponding emphasis on individual responsibilities to the rest of the community to which one belongs (Jennings , 2003) .

Central to the critique of Rawls is that it gives precedence to the establishment of the principles of justice, on the basis of recognition of a ‘common good’ by the individuals performing the social contract. Sandel (1998) attributes this position to deontological liberalism's character - whose roots lie in the philosophy of Kant. A view that reaffirms the impossibility of imposing common standards based on a single criterion of purpose (*telos*), as the primacy of individual liberty must be respected, as each individual has their own conception of the good. The Communitarianism rejects the assumption that individuals can arrive at the principles of justice based on rationality and seeking to ensure their individual interests autonomously, since the interests of the people are valued in terms of the conception of common good. Each individual person cannot bracket his convictions from his membership in a moral community that shapes his personal identity (Navarrete, 2006). Communitarianism seeks to articulate the concept of the common good, under which the concept of justice falls. The problem is what is the common good?

Some communitarians argue that the definition of common good depends on the values shared by those who make up the community, and in that sense how justice is conceived may not be derived from an argument that seeks to be outlined separate from and prior to social life, as the aims and actions of individuals are determined by the history and culture of the community in which they live (Roberts and Reich, 2002). According to Michael Walzer (1983), justice depends on the value or meaning given to goods that are distributed, which depends on the cultural and historical context (the shared concept of good). So, commodities have a given identity by the way they are conceived, produced, transferred or consumed, which means that all goods have a social character. The principles are not dependent on distributional criteria of good in itself, but of their social identity, which is a ‘sphere of justice’. Consequently, the criteria used to distribute a good, do not necessarily coincide with the criteria used to distribute other goods. For example, if health care is distributed according to the needs of health, and income according to merit, we should not pretend to distribute health care according to merit or vice versa. Hence according to Walzer, justice is based on a complex equality between people.

It could be said that communitarian health equity would imply a shared definition as a society, reflecting our history and our shared values, allocating our resources —in the broadest sense of the word— to meet health needs under the shared idea of what we mean by health. However, there are other communitarians that suggest that there is one true good, and this is the good of the 'ideal community', from which they derive all the other virtues. In this sense, the idea of the common good is a theory of "end state" that measures justice according to the social outcomes rather than the rules of fair play (Christiansen, 1989).

Communitarianism appreciates common good tradition —from Plato to Aquinas— arranging it in relation to some of the concerns of liberalism —such as respect for individual rights— but aspiring to a society in which the basic needs of all are met and all share the benefits of progress in the quality of life. So the concept of justice, from a communitarian perspective, should incorporate a positive duty of beneficence—an issue that liberals refuse absolutely (Quinn, 1996).

Therefore, regarding the concept of justice I have been elaborating, I can recognise the influence of communitarian thinking as this concept recognises the relationship of the value of justice with others such as beneficence (See 2.4; 3.4). Similarly, as this concept requires a more strong role of the agent who will be acting for the good of the recipient of such actions and the good of himself (See 4.3; 4.4) it will be important that such account be rooted in the same understanding of a shared good, a 'comon good' necessary to the goods that are owed and more specifically what defines others' rights (See 4.5).

5. The account of Justice in Health

5.1. The right to health

As I pointed out in the previous chapter, a concept of justice is not complete if it does not give an account of rights, and what I take for a right is, on the one hand, that which is owed to another, and on the other hand, the good to which a just action must intend; so that *a right* is to be understood as *the object of justice*, i.e. its realization. Therefore, to speak about the realization of such a good we name health as the object of our just actions is to speak about the right to health.

Certainly, it would be very interesting to discuss whether or not *there is* such a right as the right to health, or whether or not this is, for example, a human right. However, assuming that 'recognizing the right to health is a well-established part of international law' (Wolff, 2012) and therefore a matter of fact, what I will try to do is to discuss what is the content of such a good that is owed to people.

A starting point to define the content of the right to health is the Constitution of the World Health Organization:

> 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
>
> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human without distinction of race, religion, political belief, economic or social condition' (WHO, 1946).

Later, the International Covenant on Economic, Social and Cultural Rights recognises, as part of such rights, ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ (Art 12), acknowledging that this kind of rights requires a series of steps to be taken by State Parties to achieving progressively the full realisation of them (United Nations, 1966). According to the Committee on Economic, Social and Cultural Rights, the right to health ‘embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment’ (CESCR, 2000).

Therefore, we can say that the right to health is more than just the right to access to health care; it contains a series of other elements that determine the possibility to achieve the highest level of health. However, this does not mean that one has the right to be healthy. As Jonathan Wolff puts it, ‘the right to health seems to stand somewhere between the right to medical care and the right to be healthy’ (Wolff, 2012). The progression to the realisation of the right to health will depend on a series of social, economic, political and cultural factors related to the different elements that determine the level of health of people, being the leading one the availability of resources. In other words, it is not possible to specify the highest attainable standard of heath without considering that series of factors, either in general terms or for a given country. For, as Onora O’Neill argues, the standard of health a person can attain with locally available and affordable treatment (resources) may be too minimal, but aiming at the highest standard globally available would be excessively demanding (O'Neill, 2005).

Therefore, specifying the content of the right to health seems a problem too complex to solve without elaborating further about the idea of right as the realization of justice—that which is owed to another, and the good to which a just action must intend.

Departing from the system proposed by Wesley N. Hohfeld (Hohfeld, 1913; Hohfeld, 1917), we may classify rights into four types (Wenar, 2015; Finnis, 2011 pp.199-200): (a) ‘claim-right’, where B’s claim-right means that there is a correlative A’s duty; (b) ‘privilege’ (also known as ‘liberty-rights’), where B’s liberty-right means there is no A’s claim-right that interfere such a privilege; (c) ‘power’, where A’s power (relative to B) means that B has a liability to have his or her legal position changed by A’s action; and (d) ‘immunity’, where B’s immunity means that A has no power to change B’s legal position.

As ‘a claim-right is always either, positively, a right to be given something (or assisted in a certain way) by someone else, or, negatively, a right not to be interfered with or dealt with or treated in a certain way, by someone else’ (Finnis, 2011 p.200), we can identify the right to health as a claim-right, provided that the right to health demands somebody to provide healthcare and the conditions leading to a healthy life. This is not superfluous, as far as this implies that we need to specify the content of the right to health not only as a claim, but also as the obligations this entails. As O’Neill puts it ‘obligations and claimable rights are two perspectives on a single normative pattern: without the obligations there are no rights’ (O'Neill, 2005).

It is important to point out here that human rights are usually seen as claims that set out requirements from the standpoint of recipients, even though they entail actions or restraints by others with corresponding obligations (O'Neill, 2005; Finnis, 2011 p.206).

Such a perspective may require a progressive specification of claims, as far as such specification allows the recipients to have a legal certainty of the benefits they can expect for such a claim. Nevertheless, O´Neill correctly points out the heavy human and financial costs for those that bear obligations derived from a progressive specification of claims— that in turn requires increasing controls and accountability in order to secure the realisation of rights. Her concern is specifically focused on those whose engagement is essential to carry out actions required for the realisation of rights, just as 'the farmer and the physician'[13] are essential to have food and medicine. According to O´Neill, the costs for obligation-bearers are paid in 'increasing wariness and weariness, scepticism and resentment, and ultimately in less active engagement' (O'Neill, 2005). At the end, progressive specification of rights and increasing complexity of obligations for the benefit of the claim-bearers leads not only to rising costs but also to damaging the services 'the farmer and the physician' provide.

I propose an additional problem to that pointed out by O´Neill: the one derived from choosing among several alternative schemes of specification —where potential recipients of benefits derived from the process of specification, finally are not beneficed as they would expect if an alternative scheme would be specified.

As I explained previously, the Chilean health reform performed in Chile during president Lagos presidency, aimed at specifying the right to health in Chilean legislation through the introduction of the System of Universal Access with Explicit Guarantees in Health (AUGE),

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[13] O'Neill departs from the question proposed by Edmund Burke in *Reflections on the revolution in France*: 'What is the use of discussing a man's abstract right to food or medicine? The question is upon the method of procuring and administering them. In that deliberation I shall always advise to call in the aid of the farmer and the physician rather than the professor of metaphysics' (O'Neill, 2005).

which progressively has determined what medical procedures and interventions the patient—suffering any of a list of health problems—must receive. This was intended to facilitate legal enforcement of the right to health, and undoubtedly it has been successful in doing so (Bitran, 2013; Missoni & Solimano, 2010; Frenz, Delgado, Kaufman, & Harper, 2014). The rationale of this runs like this: A doctor (D) who is evaluating a patient (P) suspects that P got a disease listed as an 'AUGE health problem', so D has the duty to inform (notify) P the suspected disease and that this is included in AUGE system, in order to guarantee that P knows that is entitled to enrol into the examinations to confirm the disease and to receive the treatments required according to official clinical guidelines. Each examination, procedure or intervention included has a time limit to be performed and a limit of co-payment if this were needed. In the case an intervention is not performed on time, P is entitled to claim it to her health insurer directly or through the Health Watchdog; and if they fail to get it done, P can claim it to the justice.

Nevertheless, making explicit the guarantees for certain health problems meant that treatments for health problems not included in the list —known as 'No-AUGE' health problems— were deferred, as far as the process of establishing specific guarantees became in fact a way to prioritize and allocate scarce resources (BID, 2016; Greig & Olivares, 2015). As a consequence of this, and the growing prevalence of chronic diseases in an ageing population, the waiting lists for accessing healthcare interventions related to 'No-AUGE' health problems are progressively enlarging and requiring more attention from health authorities as this became one of the main political issues at present time (Bossert & Leisewitz, 2016). People that are potential recipients of healthcare interventions for 'No-AUGE' problems, are any way entitled to claim them as part of their right to health, however they have to wait for such interventions months or even years unless they were ready to spend out-of-pocket money in order to solve their problems.

The problems just described —namely (1) the increasing burdens for those who are required to accomplish the specific mandates of a set of obligations derived from the more general right to health, and (2) the deterioration of the concrete realisation of the right to health for those cases that do not fit exactly to the specifications established in order to guarantee the right to claim the access to the healthcare interventions needed— seems to be consequences of the effort to make that 'those with rights have enforceable claims, and need not to rely simply on the goodwill of others' (Wolff, 2012 Pos335). Assuming the standpoint of recipients —as a means to achieve the realisation of the right to health— entails a sort of trade-off between the gains for recipients of benefits and the burdens for those for whom these rights entail obligations and those excluded from eventual benefits in an alternative scheme or level of specification of rights.

There is a third problem arising from the specification of the right to health when we stand from the recipients' side aiming at making them enforceable claims: it produces an imbalance in favour of obligations related to the right to medical care against those related to the right to be healthy, as the later requires a series of interventions at the collective (Public Health) level, such as those aiming at curbing some social determinant of health—which are as much difficult to translate into claimable rights as ineffective in terms of practicability, at least in the context constitutions that do not recognise collective rights. Some even question 'whether the creation and judicialisation of health rights is a force good or ill' (Flood & Gross, 2014 p.1) as this might influence in increasing health inequities instead of tackling them.

In my opinion, the progressive specification of obligations derived from human rights is not a completely wrong pathway— for this process has indeed resulted in important gains for the effective realisation of the right to health. Nevertheless, it seems a pathway taken too far without exploring alternative ones.

5.2. Rights from the stand point of agent

As I mentioned above, specifying rights such as the right to health is a task that is usually assumed from the standpoint of recipients—i.e. establishing obligations for agents that recipients can effectively claim. And this, as Wolff stated, allows recipients to avoid relying on the goodwill of others.

However, not having obligations that the recipient can effectively claim does not necessarily mean they are relying on the *goodwill* of others. There are multiple examples of obligations that agents have to accomplish even though the recipients cannot claim them: parents have a duty to feed their children; men able for military service have a duty to serve in case of war; citizens have a duty to pay taxes to finance public schools or sanitary services; etcetera. It is my opinion that they represent what would be said are rights specified from the standpoint of the agents, for they are described as obligations in terms of what an agent has to do, more than what the recipient has the right to expect be done or received.

To make more clear where in my opinion lays the difference between standing from an agent's standpoint and standing from a recipient's one, I will go again to Socrates' example I used before, about someone (A) who borrowed a weapon from a friend (B), who then went mad. If we were to specify a right standing from the standpoint of the recipient (B), we will probably state that (B) has the right that (A) gives back what belongs to him; for this takes the form of an enforceable claim. Whereas, if we stand from the standpoint of the agent, we will probably say that (A) has a duty to give (B) what he owes to him. The latter is a more general formulation because what (A) owes (B) is not only giving back the weapon but also to intend the good for (B).

To be more concrete, I will now put forward an example in the context of AUGE System: One of the problems included is Type 2 Diabetes. According to the corresponding protocol, patient suffering this disease are entitled to receive a specific antidiabetic drug (G). However, there is growing evidence that this drug increases mortality rate when used by people over 65 years old. So, even though there is a clearly enforceable claim— 'B has the right to receive G if B is diabetic'— the healthcare provider has a duty to consider not to prescribe G and prescribe an alternative one, even though at present time, this may not be included as part of the claimable drugs.

The case I just described may be useful for someone to explain legal concepts such as 'Duty of care' (in countries that use Common Law) or the concept of '*Lex Artis*' (Rules of the Art) used in Spain and Latin American countries; being both concepts mainly used when it becomes a case of negligence. Even in Bioethics it may be useful to explain the principles of Beneficence and Non-maleficence (Beauchamp & Childress, 2001). I will not discuss each of these concepts here, but just to point out that this kind of situations are not unknown in ethical and legal debate regarding healthcare.

I can now formulate the content of the right to health **as the realisation of that which is owed to others intending their highest standard of health** (physical, mental and social well-being). Such a formulation requires more than a progressive codification of rules and obligations; it requires that the agent knows the good intended to do through actions that those rules and obligations are made for.

5.3. The moral agent(s) of justice in health

In chapter 4, I stated that justice is a concept that 'we can predicate about different subjects; however it is primarily predicated upon the morally relevant actions that relate a morally responsible agent with the recipient(s), or affected by, such an action' (See 4.2). Later, I explained that when we deem some agent as a just agent, it is a virtue what we are attributing to him or her; and such a virtue implies that the agent has 'the *ability* (or *capacity*) to act in a way that the outcome is one that can be deemed as just' (See 4.3). I finished that chapter concluding a concept of justice as 'the virtue of rendering each other the goods that are owed', in other words 'the virtue of rendering each other their rights'. In regarding justice in health, I stated in the previous section (See 5.2) that the realisation of the right to health is—as the (material) object of justice in health— the realisation of that which is owed to others intending their highest standard of health.

Therefore, our task now is to identify and characterise the relevant agent(s) for justice in health. Undoubtedly, there are as many possible candidates as persons, groups or institutions exist—whose actions (or absence of actions) may be deemed as relevant for people to achieve the highest standard of health. And we know that health depends not only on individual biology and behaviour; physical and social environment also contribute in determining his/her health status.

Many activities that human beings carry out in their normal life can affect either directly or indirectly the health of other human beings; therefore—as far as human beings are moral agents—they can be deemed as just or unjust regarding that which is owed to each other to achieve the highest standard of health. In many cases what is owed is to restrain of doing that which will negatively affect others' health; there are many examples of this: smoking in shared spaces, contaminating water sources, etc. There is no need to establish a law forbidding these actions to realise that they are morally unjust; therefore a virtuously just moral agent will not smoke in shared spaces or contaminate water sources.

In other cases, what is owed is to perform some actions that will improve health status of others: for example, the parents must provide nutrition for their children and compel them to wash their hands and teeth; the teachers should teach their students to prevent diseases and allow them to have time for physical activities; the doctors must tell their patients how to manage their diseases and prescribe them the right drugs; etc. All of these actions are owed to others and should be done for the good of the recipients. This requires from the agent the knowledge of such a good intended for every recipient—and most importantly for each recipient. For a just parent does not give the same food to all of her/his children if one of them requires a special diet of gluten-free food because he/she suffer a celiac disease, but makes an additional effort to provide her/him the adequate foods. Likewise, a just teacher should pay special attention to one student in the case such a student has special needs; or a doctor must spend more time and effort when a patient is severely ill. Nevertheless, I am not intending to build on every possible agent whose actions might be related to someone else´s health; I am interested in those agents whose actions can affect health in order not only to improve health status, but also to reduce health inequalities.

Following Onora O'Neill one can distinguish 'primary' and 'secondary' 'agents of justice': being primary agents of justice those agents with the power and capacities to impose tasks or restrictions or assign responsibilities to other agents —the secondary agents of justice. Meanwhile, secondary agents of justice contribute to justice meeting the demands of primary agents, mainly by conforming to their legal requirements (O'Neill, 2001).

Although they can be individuals, the typical primary agents of justice are institutions and organizations with formal structures, such as states. This idea is underlying ascriptions made in International Human Rights Instruments, such as the 'International Covenant on Economic, Social and Cultural Rights' that recognises in its preamble 'the obligation of States under the Charter of the United Nations to promote universal respect for, and observance of, human rights and freedoms'.

Similarly, in its article12, the Covenant expresses the commitment of State Parties 'to take steps to achieve the full realization' of 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. So, one can say that states are also 'Primary agents of *justice in health*' for —in order to promote improvements on health status of people living within their borders— states can establish laws, rules or norms, and have some means of coercion to control the action other agents may perform that can affect health status of others. It is also possible to count as primary agents of justice in health the ministers of health and those agencies established by one state—or even by a groups of states, such as the World Health Organization— that are directly in charge of setting up special regulations, performing inspections concerning public health, establishing regulations for health care or planning the distribution of resources for public healthcare, etc.

Here it is worth to remember that I previously said (See 4.2) that an agent can be deemed as a just or unjust agent insofar such an agent is a *moral* agent. A moral agent is the agent that (1) can be deemed as responsible of foreseeing and addressing the consequences of his/her actions or omissions, and (2) is subject to moral praise or blame for them. Nevertheless, I have to acknowledge that it is a contested matter to attribute a status of moral agent to institutions or organizations such as a state, a ministry of health or an international health agency.

Moral agency entails 'deliberating over possible courses of action and their consequences and acting on the basis of this deliberation' (Erskine, 2003 p.6). In a narrow sense, the label of moral agent is reserved for individual human beings, as far as the deliberation process of human moral agents involves a series of features such as consciousness, rationality and intentionality among other traits that institutions probably lack. Nevertheless, I agree with Erskine when affirms that one might say that for its deliberative purposes an institution does not need to conform to all the features that characterises a human moral agent (p.15).

Building upon Peter French's idea of 'artificial moral person' (French, 1984), Erskine (Erskine, 2001) explains that an institution, as a collective, can be deemed as a deliberative agent insofar (1) it has the abilities and capacities to access and process information and (2) it counts with structures of decision-making that will allow it to arrive at a predetermined goal. Similarly, institutions that we can consider as moral agents have (3) an ‘identity over time’ which means that such institutions cannot be spurious or transient, but they must have continuity. To these conditions, Erskine adds that (4) it must be self-asserting[14] meaning that the collective sees itself as a unit. Altogether, the four conditions would allow an institution to become an ‘institutional moral agent’.

In this point I shall recall Rawls’ definition of Justice I used before as a starting point in discussing the concept and conceptions of justice (See 4.1), which defines justice as the virtue of social institutions by which, on one hand, such institutions do not make arbitrary distinctions between persons when assigning basic rights and duties, and, on the other hand, social rules determine a proper balance between competing claims to the advantages of social life. Now, I do not want to go back to discuss again the concept of justice, but to compare the idea of social institutions Rawls had in mind with the idea of institutional moral agents of justice I have advanced in this section.

By an institution Rawls understands ‘a public system of rules which defines offices and positions with their rights and duties, powers and immunities, and the like […] As examples of institutions, or more generally social practices, we may think of games and rituals, trials and parliaments, market and systems of property […] An institution exists at certain time and place when the actions specified by it are regularly carried out in accordance with a public understanding that the system of rules defining the institution is to be followed’ (Rawls 1971 p.47-8).

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[14] This does not mean that it must be self-aware or conscious (Erskine, 2001 p. 72).

Although ‘defining offices and positions’ looks like an action, it is clear that it is not the intention of Rawls to assign to all social institutions, as he understand them, the character of moral agents of justice—at least in the same sense of what I already described— for the examples he gives, correspond to ‘social practices’ carried out according to certain system of rules assuming that such systems of rules *are* the social institutions. Therefore, one may say that (1) social institutions Rawls had in mind are not to be understood as moral agents—even less agents of justice in a moral sense— and (2) that primary agents of justice should not be understood just as the systems of rules that define the social practices to be followed.

The second conclusion of the previous paragraph is also important because, effectively , the kind of institutions that we are concerned about—primary agents of justice in health— are constituted not only by the rules that define them but also by the people that take part of the actions that such institutions perform intending their purposes[15]. To mention this here is important because an issue that emerges when we are referring to institutions as moral agents is the question whether moral agency is proper of the institution as such or it is proper of the individuals that are part of that institution. Indeed, this is an important issue when we are to ascribe some moral responsibility to actions carried out by institutions, especially when they are primary agents that, as we said above, have the power and capacities to impose tasks or restrictions or assign responsibilities to other agents.

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[15] On saying this, I am not talking about the specific individuals that are part of an institution in a specific time and place, but the collective of individuals without which the institution would not exist.

French addresses this issue when discusses whether corporations are to be considered moral persons (French, 1979), asserting that to ascribe some moral responsibility to actions carried out by corporations is only possible if its structure of decision-making accomplishes a subordination and synthesis of the intentions and acts of various biological persons into a 'corporate decision'. Such a decision is recognized by the policy it instantiates that can be properly described as a 'corporation's policy'.

One can extend this rationale to the institutions that we count as possible moral agents of justice in health, and judge them morally responsible when they are able of —thanks to its structures of decision-making— deliberating over possible courses of action, foreseeing and addressing their consequences, and acting accordingly. Actions carried out as consequence of such a process of deliberation—which constitutes 'institution's policy'—should be possible to recognise by any internal or external observer as characteristic of institutions that aim at the realisation of that which is owed to others intending their highest standard of health. Similarly, one can say that deliberated actions carried out by an institution as agent of justice in health constitute institution's practice that reveals institution's virtue of justice.

5.4. Justice in Health

So far, I have arrived to an ethical account concerning justice in health that I think would be able to best inform health policies such as those intending to tackle health inequalities. This account of justice in health may be described as a virtue-based account for it emphasises the role of the just agent in acting to render each other what is owed, and because it considers that to realise the justice in health such an agent requires to have a an idea of what is the highest attainable standard of heath considering the series of factors that determine such a standard. Similarly, this requires from the agent the ability or capacity to act in a way that the outcome can be deemed as just (See 4.3; 5.3).

When it comes to define health policies then, not only the specification of rules that would define what the rights of the people that those policies are intended for, but to get agents of justice that will be able to act habitually as a just agents. The main agents in this role are those that I named primary agents of justice in health, which must be understood as moral agents even though they will frequently be institutions or organisations, such as states, ministries of health, public agencies and international agencies. The important issue here is that those agents must have the capacity to deliberate and act accordingly; and therefore be deemed as responsible of achieving for the people they serve the highest standard of health.

Part III: Informing a New Health Policy

6. Justice in Health and the Problem of High-Costs Treatments

6.1. The Problem of High-Costs Treatments

The Chilean Health system reform performed during president Lagos' mandate, as described before (See 1.2.) intended to realise the right to health through explicit guarantees (AUGE) and to reduce inequalities in health. To elaborate the list of health problems included in AUGE—and the interventions required— the Ministry of Health has to consider (1) the burden of disease, (2) the effectiveness of interventions and (3) their cost-effectiveness.

Most of high-costs diagnostic procedures and treatments are expensive because the diseases they are made for are low-frequency conditions or even rare conditions, so their burden of disease is lower compared to many more frequents health problems. Likewise, cost-effectiveness for this kind of treatments is lower given their higher costs; even they had a similar effectiveness. Therefore, under AUGE system it is very difficult that very expensive treatments for rather infrequent diseases become covered; leading to a paradoxical situation for a system that aims at reducing inequalities in health:

Suppose two persons (A and B) suffering different diseases (X and Y) that are possible to treat with x' and y' respectively, and x' and y' have similar effectiveness. The only important difference for A and B is that X is significantly more frequent than Y, so X's burden is significantly higher than Y's burden. In this case, x' has a lot more chances to be included in AUGE than y'. There are cases that x' and y' are the same intervention and the only difference is that it is useful either for X or for Y; even in this case it could happen that the same intervention is guaranteed when the diagnosis is X and not when it is Y.

A concrete example of such a paradox (which I call ‘AUGE’s paradox’) is the surgery for hip replacement. This surgery is guaranteed for people suffering hip osteoarthritis, a disease that is frequent among elder people causing an important burden of disease but it is not guaranteed for people suffering a hip avascular necrosis, which is significantly less frequent than osteoarthritis.

Nevertheless, not being covered in AUGE system does not mean that a treatment has not coverage. This means that, for instance, opportune access is not guaranteed. When it comes to the financial protection this means that some diseases or treatments had partial or no coverage, so patients have to make out-of-pocket payments that could be significant. According to estimates (DESAL, 2016), in 2012 an average of 6.3% of family budget in Chile was allocated to direct health expenditures; 4% of families incurred into catastrophic expenditures (more than 40% of family budget) and 0.43% of households felt under poverty line because of catastrophic expenditures.

6.2. ‘Sick people also march’

Ricarte Soto was a journalist and figure of Chilean television. In 2010, he was diagnosed an advanced lung cancer and the only possible treatment to grant him some chances of survival was a high-cost medicine. Even though such a treatment was not covered by private or public insurances, he was able to afford its high expenses. After two years of treatment he appeared on TV talking about his disease and saying ‘At some point I felt uncomfortable about having the means to do everything quickly, because in cancer everything has to be done quickly ... Then I said 'why am I such an idiot; the problem is not that I receive this kind of care, the problem is that in Chile many cancer patients do not have the possibilities that I have’ (Emol.com, 2012). He then started a personal crusade to press the authorities to create a mechanism to finance universal coverage for high-cost treatments. His crusade led to an impressive social mobilization during 2013 that had its peak in May when more than ten thousand people suffering some disease participated in a march in Santiago —many of them on wheelchairs. After such a demonstration and Ricarte Soto’s death in September, the issue became one of the key issues for the presidential elections at the end of that year, and most of the candidates promised to create a mechanism to deal with the financing of high-cost treatment.

Immediately after assuming as president, Dr. Michelle Bachelet instructed to her cabinet to propose a bill to create a mechanism to finance high-cost treatments not included in AUGE system. As Vice-Minister of Public Health, I was commissioned to lead the elaboration of the proposal and later to participate in the parliamentary debate that concluded with a law that ‘Creates a financial protection system for high cost diagnoses and treatments and render posthumous tribute to Don Luis Ricarte Soto Gallegos’ enacted in June 2015 (Law No. 20,850, 2015) which became known as ‘Ricarte Soto’s Law’ (LRS).

6.3. Ricarte Soto’s Law

The LRS creates a system that provides universal coverage and financial protection to all users of health care system—regardless of their socioeconomic status—that require a high-cost diagnostic procedures or treatments (medicines, special foods or medical devices). Which diagnoses and treatments are included in this system are defined through a process that includes an active participation of patients and other civil society representatives. Until now and as a first step, the LRS considers the diagnosis and treatment of 14 health problems.

LRS defines high-cost diagnostic procedures as ‘the set of benefits that are demonstrably useful for the confirmation and subsequent control and treatment of the disease, when their costs impede access to treatment or have a catastrophic impact on the expenditure of the beneficiary’, meanwhile defines high-cost treatments as ‘medicines, foods or elements of medical use associated with diseases or health conditions and for the services essential for diagnostic confirmation and follow-up, which by their cost prevent access to these, or accessing, catastrophically impact on the beneficiaries' spending’ (Law No.20,850; 2015 Art.2). The key concept of these definitions is the notion of catastrophic expenditure. In order to implement the previous conceptions of what is considered high-cost and catastrophic expenditure both Ministry of Health and Ministry of Finance defined high-cost as health expenditure of a household exceeding 40 percent of the average family income, discounted basic living expenses. For the period 2015-2018 the calculated threshold is USD 3,720 a year; this means that only technologies costing more than this are potential candidates for LRS’s coverage.

In order to be able to determine what high-cost diagnoses and treatments will be finally covered the Law establishes a process that includes four steps: (1) Scientific evaluation of the evidence, (2) feasibility evaluation, (3) prioritised recommendation and (4) decision. The four steps are summarised below:

(1) Scientific evaluation of the evidence: the Under-secretariat of Public Health[16] carries out a scientific evaluation based on available evidence, for the diagnosis or treatment of a specific health condition. To define which diagnoses and treatments will be evaluated, the Under-secretariat of Public Health must take into account the opinions and recommendations of technical advisory commissions, patient groups and citizens; the latter, through the Office of Information, Complaints and Suggestions (OIRS).

    Scientific evidence is obtained through the review of studies of effectiveness in databases and is complemented with reports of evaluation of health technologies of recognized international agencies, such as the National Institute for Care and Health Excellence (NICE), Canada's Canadian Agency for Drugs and Technologies in Health (CADTH), Australia's Pharmaceutical Benefits Advisory Committee (PBAC) and the Institute for Health Technology Assessment (IETS) in Colombia. Evaluations include the following elements: (a) Relative effectiveness and effectiveness on criteria such as mortality, disease-free or progression-free life years, and quality of life; (b) Patient safety through the health registry and the drug or techno-surveillance performed by high health surveillance agencies; (c) Economic evaluation, which includes evaluation of payment terms through the risk-sharing mechanism and budget impact and price regulation (d) Ethical, legal and social repercussions

(2) Feasibility evaluation: this is carried out by Under-secretariat of Healthcare Network to the technical and logistical capacities of the public, private and armed forces

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[16] The Ministry of Health of Chile has two Under-secretariats: the Under-secretariat of Public Health that assumes the role of protection of collective health through epidemiological surveillance and collective interventions such as immunisation and the role of elaboration of public policies and regulatory frameworks; meanwhile, the Under-secretariat of Healthcare Network coordinates and controls the public healthcare services including primary, secondary and tertiary services.

healthcare network, in order to provide high-cost diagnostic procedures or treatments that under evaluation by the Under-secretariat of Public Health. Feasibility evaluation and scientific evaluation of the evidence are included technical report has to be published 15 days before the next step.

(3) Prioritised recommendation: This is a novel and key step established in the LRS. Article 8 mandates the creation of a Prioritised Recommendation Commission (CRP), composed of 10 experts selected through a process of public examination of their qualifications (in the fields of medicine, public health, economics, bioethics, health, drugs, medical devices and special foods) and two representatives elected by patient organizations. The role of CRP is pretty much like the role of a jury in a trial in anglo-saxon countries: the evidence obtained through the previous steps in the process is presented to the members of CRP who later deliberate on the scientific, economic and social value of the high-cost diagnoses and treatments evaluated. The deliberation is recorded and is part of the CRP report. The conclusion of such a report is a public recommendation to the Minister of Health of prioritisation of the list of high-cost diagnoses and treatments evaluated. CRP's recommendation can be challenged by any person within 5 business days after publication.

It is important to note that CRP has some innovative aspects: (1) it includes representatives of patients; (2) participation of experts is strongly regulated to ensure their independence and to avoid potential conflicts of interest: it forbids participation of: (a) anyone with personal or relative interest up to the fourth degree of consanguinity and second degree of affinity; (b) any individual who has received total or partial financing, monetary transfers or contributions of any nature for travel, consulting, consultancy, research or any other activity, whether for personal use, his spouse or partner, or any relatives up to the fourth degree of consanguinity and second of affinity; (c) anyone that have a share in the ownership of registrations, patents, sanitary authorization of drugs or in the ownership of healthcare facilities. These inabilities apply to within 24 months prior to appointment.

(4) Decision: in this step, Ministry of Health and Ministry of Finance determine the diagnosis procedures and treatments that will be finally covered. The Ministry of Finance guarantees financial sustainability. The services included in this final package should not exceed 80% of the fund allocated for that year.

To ensure participation of the community and accountability in the implementation of LRS, law mandates the creation of the Citizen Commission for Monitoring and Control whose function is to advise the Ministers of Health and Finance, monitor the operation of the system and make recommendations through the generation of an annual report. The members of this commission are four representatives of patients, two representatives of scientific societies, two academics from medical faculties, and four health experts appointed by the Minister of Health. They hold their position during a four years period.

Currently, LRS covers treatments for 14 diseases (11 since 2016 and three that were added this year) and it has benefited 5,990 patients since its entry into force.

6.4. Justice in Health and Ricarte Soto's Law

As I described in previous sections of this chapter, LRS was a response to the high-cost treatments' problem. AUGE system, which was intended to realise the right to health through explicit guarantees and to reduce inequalities in health was unable to deal with this problem. On the contrary, the rules established in AUGE system to define which treatments are to be included as guarantees make it very difficult that high-cost treatments get coverage. This represents a failure—at least partial— on achieving its objectives and the kind of equity it was supposed to look for: a 'Democratic Equality', where social and economic inequalities produce benefits for everyone and particularly for the least advantaged. Lack of coverage for high-cost treatments make them impossible to access for less advantaged and put in risk of impoverishment those that are not in poverty.

The failure of the AUGE system regarding high-costs treatments does not imply a failure on the account of justice that supposedly justified the implementation of such a system; Rawls himself proposes a method of 'Reflective Equilibrium' (Rawls, 1971 pp.19-21, 48-51) that in a narrow sense consists on a back and forward process to 'eliminate irregularities' and make fit moral judgements with the set of general moral principles (Daniels, 1996) (Daniels 1996 p.67). Indeed, regarding the problem of high-cost treatments, it was possible to evaluate and re-formulate the rules of AUGE system in a way that it was able to deal with such a problem.

However, after a process of deliberation within the Ministry of Health and between this and the Ministry of Finance, the government decided to create the system that LRS later embodied. The reasons for this decision were on one hand, to avoid that changes on AUGE could result on emerging new problems for whom this government may be blamed in the future (the 'political' reason); on the other hand, to introduce more flexibility in the decision-making process; as we were aware that establishing a set of rules that by themselves would allow to define what high-costs treatments should be guaranteed would be a very complex task as it could not include usual tools such as calculating the burden of disease or the cost-effectiveness of the treatments due to the problems exposed before (See 6.1.) (the ‘technical’ reason).

It is important to note that a more ‘flexible’ process of decision-making does not mean lack of rules or procedures; it means that decisions would not necessarily depend just on rules or procedures defined beforehand. It was clear that a new system should require rules for example to gather and to evaluate the scientific evidence of candidate high-costs treatments and it was also clear that in some point a decision that would lead to include some treatments and to exclude other treatments should be taken; a decision that should be deemed as a just decision.

In order to give public guarantee that decision would be transparent and not arbitrary, we proposed to strengthen the capacities of the Ministry of Health creating a formal space of deliberation that would allow representatives of civil society to participate on the decision-making process. Likewise, this proposal was an opportunity for me to see in practice the idea of treating the Ministry of Health as an institutional primary agent of justice.

So far, the decisions made as part of LRS system has not being criticised because of the selected treatments to guarantee, but only because the number of treatments to guarantee could be higher whether the Ministry of Finance would provide more resources for funding..

Conclusions

Through the present thesis I have conducted an enquiry exploring the role of justice when informing health policies such as the reforms of health systems or those aimed at tackling health inequalities.

I firstly found that competing accounts of justice inform different positions regarding political decisions in health; nevertheless, political debate is barely aware of the sources of the differences between those different positions. This makes it harder to find the consensus required to shape policies that have wider support so they become more effectives in pursuing the objective of achieving the highest standard of health possible.

Similarly, it is possible to conclude that none of the accounts that at present time are at stage disputing the role of informing the decisions regarding the distribution of benefits and burdens in the society is good enough when it comes to health matters. In fact, most of the major representatives of political philosophy, as Rawls, avoid including health as a matter of study of their respective theories. And those that adventure to do so have difficulties to demonstrate coherence between their starting point and the proposals they arrive, like Daniels. Certainly, I am neither concluding nor suggesting that such theories of justice or justice in health respectively should be dismissed; for firstly, they do not pretend to develop an omni-comprehensive theory—as Rawls acknowledges (1985)–that gives an answer for every possible questioning. Although, the intention of people like Rawls, Daniels and many others is to settle certain principles from which one can derive rules of action when it comes to dilemmas regarding distribution of benefits and burdens.

And their proposals are pretty sound for people that are concerned with the problem of health inequalities.

Nevertheless, the challenge that inequalities in health represent demand from us to question such accounts either to perfection them through a better understanding or to use alternative accounts that maybe could better inform our decisions in health policy.

I tried to do so revisiting the very concept of justice and in my enquiry I found that the fundamental basis of this is that justice is a relational concept that involves actions that relate agents with recipients regarding a relevant good. So, when it comes to the moral judgement to deem something as just what is right is not the only that matters but also the good that is intended for the recipient. Then, there is no sense of establishing a sort of precedence of the right over the good.

In performing actions under the scope of justice, the agent put in practice the virtue of justice and in doing just actions the agent becomes virtuous in its benefit and in the benefit of the recipient(s) of such actions. In order to carry out just actions the agent requires the knowledge of the good that intend with such actions.

When we think about role of institutions as agents of justice it is important to acknowledge that they are moral agents insofar they are able to deliberate and act accordingly for what they can be morally praised or blamed, i.e. they are morally responsible. Then, it is a central task when dealing with health policies to realise that moral agency of the institutions is a central issue; and that those polices should consider how they implies improving their abilities and capacities to deliberate and to act according to such deliberation.

The example of implementing a new system to address the unequal access to high-costs medicines and its impact in the socio-economic situation of those that need to get them was a good opportunity to put in practice this account, designing a mechanism of deliberation that involves participation of patients in an institutionalised way.

Indeed, there are many issues that probably were left aside in the development of this enquiry, some of them consciously others not. I apologises of that if they were necessary to understand the content of this thesis. In any case, there would be important in the future to continue this enquiry addressing some of those issues left aside.

One important issue that requires further research concerns the content of the good that is intended when actions are made intending the highest standard of health. As we realise that actions are driven intending some good, developing an account of goodness as rationality (as the reason-to-act) is a central matter for informing just decisions in health.

Another important issue that should be relevant to address in further research is the impact that progressive specification of the right to health has on agents in health field especially for those that have to decide about issues that are relevant for justice.

Finally, it is also important to further study what is required to allow agents in health either individuals or institutions to perfect their role as agents of justice and becoming virtuous in doing so.

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