My view on justice in regard to health is distinctive in two ways. First, I hold that the strength of our moral reasons to prevent or to mitigate particular medical conditions does not depend only on what one might call distributional factors, such as how badly off the people affected by these conditions are in absolute and relative terms, how costly prevention or treatment would be, and how much patients would benefit from a given treatment. Rather, it depends also on relational factors, that is, on how we are related to the medical conditions they suffer. This point is widely accepted in regard to conduct. You have, for instance, stronger moral reason to make sure that people are not harmed through your negligence than you have to ensure that they are not harmed through causes outside your control (others’ negligence or their own, say, or bad weather). And your moral reason to help an accident victim is stronger if you were materially involved in causing her accident.

I assert an analogous point also in regard to any social institutions that agents are materially involved in upholding: in shaping an institutional order, we should be more concerned, morally, that it not contribute substantially to the incidence of medical conditions than we should be that it prevent medical conditions caused by other factors. Thus, we should design any institutional order so that it prioritizes the alleviation of those medical conditions to which it substantially contributes. In institutional contexts as well, what is important to moral assessment is not merely the distribution of health outcomes as such, but also whether and how social factors contribute to their incidence. The latter consideration is needed to distinguish different degrees of responsibility for medical conditions and for their prevention and mitigation.

My second thesis builds on the first. It is generally believed that one’s moral reason to help prevent and mitigate others’ medical conditions is stronger when these others are compatriots than when they are foreigners. I reject this belief in regard to medical conditions in whose incidence one is materially involved. People can be so involved through their ordinary conduct or through their role in upholding an institutional order. In the case of ordinary interpersonal relations, for example, one’s moral reasons to drive carefully and to help victims of any accident one has caused do not weaken when traveling abroad. And in institutional contexts, we ought especially to ensure that any institutional order we help impose avoids causing adverse medical conditions and makes the alleviation of any medical conditions it does cause a priority. Here my second thesis holds that this responsibility is not sensitive to

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whether the medical conditions at stake are suffered by foreigners or by compatriots.

Putting both theses together, I hold then that foreigners’ medical conditions in whose incidence we are materially involved have greater moral weight for us than compatriots’ medical conditions in whose incidence we are not materially involved. In interpersonal contexts, this combined thesis is not likely to be very controversial. Suppose two children have been injured by speeding drivers and money is needed to pay for an expensive medical treatment necessary to restore their health and appearance completely. In one case, the child is a foreigner and you were the driver. In the other case, the child is a compatriot and someone else was the driver. My view entails that in a situation like this you have (other things being equal) stronger moral reason to buy the expensive treatment for the foreign child, and most would probably agree.

In institutional contexts, by contrast, my view is likely to be quite controversial. It might be stated as follows: Foreigners’ medical conditions, if social institutions we are materially involved in upholding substantially contribute to their incidence, have greater moral weight for us than compatriots’ medical conditions in whose causation we are not materially involved. This combined thesis is radical if social institutions we are materially involved in upholding do substantially contribute to the incidence of medical conditions abroad. Is this the case?

SOCIAL INSTITUTIONS, POVERTY, AND HEALTH

Many kinds of social institutions can substantially contribute to the incidence of medical conditions. Of these, economic institutions—the basic rules governing ownership, production, use, and exchange of natural resources, goods, and services—have the greatest impact on health. This impact is mediated, for the most part, through poverty. By avoidably engendering severe poverty, economic institutions substantially contribute to the incidence of many medical conditions. And persons materially involved in upholding such economic institutions are then materially involved in the causation of such medical conditions.

In our world, poverty is highly relevant to human health. In fact, poverty is far and away the most important factor in explaining existing health deficits. Because they are poor, 815 million persons are malnourished, 1.1 billion lack access to safe water, 2.4 billion lack access to basic sanitation, more than 880 million lack access to health services, and approximately 1 billion have no adequate shelter.1 Because of poverty, “Two out of five children in the developing world are stunted, one in three is underweight and one in ten is wasted.”2 About one-third of all human deaths are due to poverty-related causes.3

This massive poverty is not due to overall scarcity. At market exchange rates, the international poverty line corresponds today to about $10 per person per month in a typical

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developing country.\(^4\) The 1.2 billion persons living below this line—30 percent below on average—thus have an aggregate annual income of roughly $100 billion. By contrast, the aggregate gross national incomes of the twenty-three “high-income OECD countries” with 852 million citizens amount to over $24 trillion.\(^5\) However daunting the figure of 1.2 billion poor people may sound, global inequality is now so enormous that even doubling or tripling the incomes of all these poor people solely at the expense of the high-income countries would barely be felt in the latter.\(^6\)

It cannot be denied that the distribution of income and wealth is heavily influenced by economic institutions, which regulate the distribution of a jointly generated social product. What can be said, and is said quite often, is that the economic institutions that substantially contribute to extreme poverty in the developing world are local economic institutions in whose imposition we, citizens of the developed countries, are not materially involved. Economists tirelessly celebrate the success stories of the Asian tigers or of Kerala (a state in India), leading us to believe that those who remain hungry have only their own institutions and governments (and hence themselves and their own compatriots) to blame. Even the philosopher Rawls feels called upon to reiterate that poverty has local explanations: “The causes of the wealth of a people and the forms it takes lie in their political culture and in the religious, philosophical, and moral traditions that support the basic structure, as well as in the industriousness and cooperative talents of its members, all supported by their political virtues….Crucial also is the country’s population policy.”\(^7\)

It is quite true, of course, that local economic institutions, and local factors more generally, play an important role in the reproduction of extreme poverty in the developing world. But this fact does not show that social institutions we are materially involved in upholding play no substantial role. That the effects of flawed domestic institutions are as bad as they are is often due to global institutions—to the institution of the territorial state, for instance, which allows affluent populations to prevent the poor from migrating to where their work could earn a decent living.\(^8\) Global institutions also have a profound impact on the indigenous institutional schemes of developing countries. By assigning those who can gain effective power in a developing country the authority to borrow in the name of its people and to confer legal ownership rights for the country’s resources, our global institutional order greatly encourages the undemocratic acquisition and exercise of political power in especially the resource-rich developing countries.\(^9\)

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\(^6\) In fact, it is claimed that the world’s richest individuals could comfortably solve the problem out of their income from safe investments: “The additional cost of achieving and maintaining universal access to basic education for all, basic health care for all, reproductive health care for all women, adequate food for all and safe water and sanitation for all is... less than 4% of the combined wealth of the 225 richest people in the world” (UNDP, *Human Development Report 1998*, p. 30). The WHO Commission on Macroeconomics and Health (chaired by Jeffrey Sachs) has sketched how deaths from poverty-related causes could be reduced by 8 million annually at a cost of $62 billion per year (*Economist*, December 22, 2001, pp. 82–83).


The national institutional schemes of developed countries, too, can have a profound influence on the national institutional schemes of developing countries. An obvious example is that, until quite recently, most developed countries (though not, after 1977, the United States) have allowed their firms to pay bribes to officials of developing countries, and even to deduct such bribes from their taxable revenues. Such authorization and moral support for bribery have greatly contributed to the now deeply entrenched culture of corruption in many developing countries.

If the social institutions of the developed countries and the global institutional order these countries uphold contribute substantially to the reproduction of poverty, then it is hard to deny that we citizens of developed countries are therefore materially involved in it as well. It is true, of course, that these institutions are shaped by our politicians. But we live in reasonably democratic states where we can choose politicians and political programs from a wide range of alternatives, where we can participate in shaping political programs and debates, and where politicians and political parties must cater to the popular will if they are to be elected and reelected. If we really wanted our domestic and international institutions to be shaped so as to avoid reproducing extreme poverty, politicians committed to that goal would emerge and be successful. But the vast majority of citizens of the developed countries want national and global institutions to be shaped in the service of their own interests and therefore support politicians willing so to shape them. At least the citizens in this large majority can then be said to be materially involved in the reproduction of poverty and the associated health deficits. And they, at least, have then stronger moral reason to discontinue their support, and to help the foreign victims of current institutions, than to help fund most services provided under ordinary health programs (such as Medicare) for the benefit of their compatriots—or so the view I have outlined would suggest.

Superficially similar conclusions are sometimes defended on cost/benefit grounds, by reference to how thousands of children in the developing countries can be saved from their trivial diseases at the cost of terminal care for a single person in a developed country. My view, by contrast, turns on the different ways in which we are related to the medical conditions of others, and thus it may tell us to favor foreigners even if costs and benefits are equal.

This summary of my larger view on health equity was meant to be introductory, not conclusive. Seeing what is at stake, I would expect even the most commonsensical of my remarks about the explanation of global poverty to be vigorously disputed; and I certainly do not believe that this brief outline can lay such controversies to rest.

TREATING RECIPIENTS JUSTLY VS. PROMOTING A JUST DISTRIBUTION

The justice of conduct, persons, and social institutions is often thought to depend sole-
ly on the distribution of relevant goods and ills that they bring about. On such a view, alternative arrangements of a health-care system, for instance, are assessed solely on the basis of the distribution of health outcomes each would tend to produce. By focusing exclusive moral attention on those who experience justice and injustice, such a view deploys what one might call a passive concept of justice.

An important alternative to this passive concept adds an essential place for (what I call) the agents of justice, for those who have or share moral responsibility for justice or injustice. I call it the active concept of justice, because it diverts some attention from those who experience justice and injustice to those who produce them. This modification is significant in several ways: for something to be unjust, there must be some identifiable agent or agents responsible for its injustice or for making it (more) just. Some agents may have responsibilities with respect to some injustice while others do not—unlike you, I may have no moral reason to seek to prevent or to remedy a minor injustice in your spouse’s conduct toward your children. There may also be gradations, as when moral responsibility with regard to the injustice of some institutional order varies from agent to agent within its scope; being privileged or influential may strengthen moral responsibilities, being poor or burdened by many other responsibilities may weaken them. Furthermore, as this last thought suggests, there may be competing claims—one may have responsibilities with regard to several injustices and may then have to decide how much of an effort one ought to make with regard to each. These issues concerning responsibilities and their prioritization are crucial for giving justice a determinate role in the real world. And they tend to be overlooked from the start, or grossly oversimplified, when the topic is approached in terms of the passive concept of justice.  

Associated with these contrasting concepts of justice are two fundamentally different ways of understanding contemporary egalitarian liberalism. One variant sees its core in the idea that no citizen ought to be worse off on account of unchosen inequalities. This idea, duly specified, defines an ideal society in which no person is worse off than others except only as a consequence of free and informed choices this person has made. In such a society, social institutions, and perhaps all other humanly controllable factors as well, are then to be aimed at promoting such a solely choice-sensitive overall distribution of quality of life. The other variant sees the core of egalitarian liberalism in the idea that a liberal society, or state, ought to treat all its citizens equally in terms of helps and hindrances. Such equal treatment need not be equality-promoting treatment. Preexisting inequalities in, for example, genetic potentials and liabilities—however unchosen by their bearers—are not society’s responsibility and are not to be cor-

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rected or compensated at the expense of those favored by these inequalities.

The health-equity theme provokes the most forceful clash of these two variants of egalitarian liberalism. One side seems committed to the indefinite expansion of the health-care system by using it to neutralize (through medical research, treatment, alleviation, and compensation) all handicaps, disabilities, and other medical conditions from which persons may suffer through no fault of their own. The other side seems committed to the callous (if not cruel) view that we, as a society, need do no more for persons whose health is poor through no fault of ours than for persons in good health. Most contemporary theorists of justice take the purely recipient-oriented approach, though they do not explicitly consider and reject the relational alternative I propose. Much of the current debate is focused on the question of how we are to judge the justice of overall distributions or states of affairs in a comparative way.

But should we judge the justice of conduct, people, and/or social rules solely by their impact on the quality of such overall distributions? With respect to conduct, most would reject this purely recipient-oriented mode of assessment. Abstractly considered, a situation in which everyone has at least one eye and one kidney is surely morally better than (an otherwise similar) one in which some, through no fault of their own, have no functioning eye or kidney while many others have two. But actions and persons promoting such an abstractly better distribution are nevertheless judged gravely unjust.

Cases of this kind may be used to draw the conclusion that we ought to distinguish between treating recipients justly and promoting a good distribution among recipients. With respect to social rules, a similar distinction would seem to be called for, and for similar reasons. Just social rules for the allocation of donated kidneys favor those who, through no fault of their own, have no functioning kidney over those who have one; and such rules thereby promote a better distribution of kidneys over recipients. Just social rules do not, however, mandate the forced redistribution of kidneys from those who have two to those who have none, even though doing so would likewise promote a better distribution of kidneys over recipients. Nor are just rules ones that produce a better distribution of kidneys by engendering severe poverty that compels some people to sell one of their kidneys so as to obtain basic necessities for themselves and their families.

Medical conditions that are intrinsically identical need not then be morally on a par.

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14 Advocates of the first view could also be accused of callousness in that the huge demands they make on behalf of persons whose health is poor through no fault of their own will, in the real world, shrink the domain of recipients—typically in line with national borders. The billions of dollars required for providing our compatriots with all the “services needed to maintain, restore, or compensate for normal species-typical functioning” (Norman Daniels, Just Health Care [New York: Cambridge University Press, 1985], p. 79) would suffice to save countless millions abroad who now die from poverty-related causes, such as malnutrition, measles, diarrhea, malaria, tuberculosis, pneumonia, and other cheaply curable but all-too-often fatal diseases.

an institutional order avoidably gives rise to
depends on how patients came to be dependent on a single kidney. Was the other
one forcibly taken from them through a legally authorized medical procedure (forced redistribution)? Were they obliged to sell it to obtain food? Or did it atrophy on account of a genetic defect? How important the avoidance, prevention, and mitigation of renal failures are for the justice of an institutional order depends on which of these scenarios it would exemplify. Once again, treating recipients justly does not boil down to promoting the best distribution among them—what matters is how social rules treat, not how they affect, the set of recipients.

This simple thought has been remarkably neglected in contemporary work on social justice. It is not surprising, of course, that it plays no role in consequentialist theorizing. Consequentialists, after all, hold that social rules (as well as persons and their conduct) should be judged by their impact on the overall outcome, irrespective of how they produce these effects. Consequentialists hold, that is, that the justice of social rules is determined exclusively by the quality of the overall distribution (of goods and ills, or quality of life) produced by these rules.

It is remarkable, however, that supposedly deontological approaches, such as that developed by Rawls and his followers, likewise make the justice of social rules depend exclusively on the overall distribution these rules produce. As the thought experiment of the original position makes vivid, Rawls agrees with consequentialists that the moral assessment of a social order should be based solely on what overall distribution of goods and ills it, in comparison to its feasible alternatives, tends to produce among its recipients. By judging any social order in this purely recipient-oriented way, Rawls ensures from the start that it is judged exclusively by its “output” in terms of what overall distribution of quality of life it produces among its participants—without regard to the way in which it affects the quality of life of these people.

RELATIONAL RESPONSIBILITIES

The most plausible alternative structure for a conception of social justice would involve weighting the impact that social institutions have on the relevant quality of life according to how they have this impact. Let me illustrate this structure by distinguishing, in a preliminary fashion, six basic ways in which a social order may have an impact on the medical conditions persons suffer under it. This illustration distinguishes scenarios in which some particular medical condition suffered by certain innocent persons can be traced to the fact that they, due to the arrangement of social institutions, avoidably lack some vital nutrients V (the vitamins contained in fresh fruit, perhaps, which are essential to good health). The six scenarios are arranged in order of their moral weight, according to my intuitive, pre-reflective judgment:

- In scenario 1, the nutritional deficit is officially mandated, paradigmatically by the law: legal restrictions bar certain persons from buying foodstuffs containing V.
- In scenario 2, the nutritional deficit results from legally authorized conduct of private persons: sellers of foodstuffs containing V lawfully refuse to sell to certain persons.

16 Other things must be presumed to be equal here. The moral weight of the health impact declines as we go through the list. But a morally less weighty impact may nevertheless outweigh a weightier one if the former is more severe or affects more persons or is more cheaply avoidable than the latter. In this way, an advantage in reducing scenario-4 type deficits may outweigh a much smaller disadvantage in engendering scenario-3 type deficits, for example.
• In scenario 3, social institutions foreseeably and avoidably engender (but do not specifically require or authorize) the nutritional deficit through conduct they stimulate: certain persons, suffering severe poverty within an ill-conceived economic order, cannot afford to buy foodstuffs containing V.

• In scenario 4, the nutritional deficit arises from private conduct that is legally prohibited but barely deterred: sellers of foodstuffs containing V illegally refuse to sell to certain persons, but enforcement is lax and penalties are mild.

• In scenario 5, the nutritional deficit arises from social institutions avoidably leaving unmitigated the effects of a natural defect: certain persons are unable to metabolize V due to a treatable genetic defect, but they avoidably lack access to the treatment that would correct their handicap.

• In scenario 6, finally, the nutritional deficit arises from social institutions avoidably leaving unmitigated the effects of a self-caused defect: certain persons are unable to metabolize V due to a treatable self-caused disease—brought on, perhaps, by their maintaining a long-term smoking habit in full knowledge of the medical dangers associated with it—and avoidably lack access to the treatment that would correct their ailment.

This differentiation of six ways in which social institutions may be related to the goods and ills persons encounter is preliminary in that it fails to isolate the morally significant factors that account for the descending moral weight of the relevant medical conditions. Lacking the space to do this here, let me merely venture the hypothesis that what matters is not merely the causal role of social institutions, how they figure in a complete causal explanation of the nutritional deficit in question, but also (what one might call) the implicit attitude of social institutions toward this deficit.\(^{17}\)

My preliminary classification is surely still too simple. In some cases one will have to take account of other, perhaps underlying causes; and one may also need to recognize interdependencies among causal influences and fluid transitions between the classes.\(^{18}\) Bypassing these complications here, let me emphasize once more the decisive point missed by the usual accounts of justice: to be morally plausible, a criterion of social justice must take account of—and its application thus requires information about—the particular relation between social institutions and human quality of life, which may determine whether some institutionally avoidable deficit is an injustice at all and, if so, how great an injustice it is. Such a criterion must take into account, that is, not merely the comparative impact a social order has on the distribution of quality of life, but also how it exerts this influence. If this is right, then it is no more true of social rules than of persons and conduct that they are just if and insofar as they promote a good overall distribution. Appraising overall distributions of goods and ills (or of quality of life) may be an engaging academic and theological pastime, but it fails to give plausible moral guidance where guidance is needed: for the assessment and reform of social rules as well as of persons and their conduct.

\(^{17}\) This implicit attitude of social institutions is independent of the attitudes or intentions of the persons shaping and upholding these institutions: only the former makes a difference in how just the institutions are—the latter only make a difference in how blame-worthy persons are for their role in imposing them.

\(^{18}\) The case of smoking, for instance, may exemplify a fluid transition between scenarios 2 and 6 insofar as private agents (cigarette companies) are legally permitted to try to render persons addicted to nicotine.
IN CONCLUSION

An institutional order can be said to contribute substantially to medical conditions if and only if it contributes to their genesis through scenarios 1, 2, and 3. Supposing that at least the more privileged adult citizens of affluent and reasonably democratic countries are materially involved in upholding not only the economic order of their own society but also the global economic order, we can say two things about such citizens: Pursuant to my second thesis, they have equally strong moral reasons to prevent and mitigate compatriots’ medical conditions due to avoidable poverty engendered by domestic economic institutions as they have to prevent and mitigate foreigners’ medical conditions due to avoidable poverty engendered by global economic institutions. And pursuant to my combined thesis, they have stronger moral reason to prevent and mitigate foreigners’ medical conditions due to avoidable poverty engendered by global economic institutions than to prevent and mitigate compatriots’ medical conditions that are not due to mandated, authorized, or engendered deficits.

In the United States, some 40 million mostly poor citizens avoidably lack adequate medical insurance. Due to their lack of coverage, many of these people suffer, at any given time, medical conditions that could be cured or mitigated by treatment not in fact accessible to them. This situation is often criticized as manifesting an injustice in the country’s social order. Now imagine that the poverty of the 40 million were so severe that it not only rendered them unable to gain access to the medical care they need (scenarios 5 and 6), but also exposed them to various medical conditions owing specifically to poverty-related causes (scenario 3). This additional feature, which plays a substantial role for some fraction of the 40 million, considerably aggravates the injustice—and it is central to the plight of the world’s poorest populations. These people generally lack access to adequate care for the medical conditions they suffer, of course. But the main effect of an extra $50 or $100 of annual income for them would not be more medical care, but much less need for such care. If they were not so severely impoverished, they would not suffer in the first place most of the medical conditions for which, as things are, they also cannot obtain adequate treatment.

I have tried to lend some initial plausibility to the view that such poverty-induced medical conditions among the global poor are, for us, morally on a par with poverty-induced medical conditions among the domestic poor and of greater moral weight than not-socially-induced medical conditions among poor compatriots. In the first two cases, but not in the third, we are materially involved in upholding social institutions that contribute substantially to the incidence of medical conditions and of the countless premature deaths resulting from them.