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TOM L. BEAUCHAMP
LEROY WALTERS
JEFFREY P. KAHN
ANNA C. MASTROIANNI

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Edited by

Tom L. Beauchamp
Kennedy Institute of Ethics and Department of Philosophy
Georgetown University

LeRoy Walters
Kennedy Institute of Ethics and Department of Philosophy
Georgetown University

Jeffrey P. Kahn
Center for Bioethics
University of Minnesota

Anna C. Mastroianni
School of Law and Institute for Public Health Genetics
University of Washington

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MADISON POWERS AND RUTH FADEN

Social Justice, Inequality, and Systematic Disadvantage

Madison Powers is Director of and Senior Research Scholar at the Kennedy Institute of Ethics at Georgetown University and Professor of Philosophy at Georgetown. He is co-editor of *AIDS, Women and the Next Generation*. His research interests include political and legal philosophy, especially issues of distributive justice.

Ruth Faden is the Philip Franklin Wagley Professor of Biomedical Ethics and Executive Director of the Johns Hopkins Berman Institute of Bioethics, and also a Senior Research Scholar at the Kennedy Institute of Ethics, Georgetown University. She is co-author and editor of books on biomedical ethics that include *A History and Theory of Informed Consent; AIDS, Women and the Next Generation*; and *HIV, AIDS and Childbearing*.

INTRODUCTION

Social justice is concerned with human well-being. In our view, well-being is best understood as involving plural, irreducible dimensions, each of which represents something of independent moral significance.

From Madison Powers and Ruth Faden. *Social Justice: The Moral Foundations of Public Health and Health Policy*. New York: Oxford University Press, 2006. Used by permission.

Although an exhaustive, mutually exclusive list of the discrete elements of well-being is not our aim (and may not be possible), we build our account around six distinct dimensions of well-being, each of which merits separate attention within a theory of justice. These different dimensions offer different lenses through which the justice of political structures, social practices, and institutions can be assessed. Without attention to each dimension, something of salience goes unnoticed.

Not all dimensions of human well-being are centrally important within a theory of social justice. Some aspects of human well-being are matters of great importance to particular individuals because they are central to their specific goals and personal aspirations. Social justice, by contrast, is concerned with only those dimensions of well-being that are of special moral urgency because they matter centrally to everyone, whatever the particular life plans and aims each has.

Our theory does not require or suppose that a threshold level of each dimension of well-being identified by our theory of social justice is a *necessary* condition for a decent life. Indeed, for many of us, even this is not the case. However, we do claim that to the extent that a human life is seriously deficient in one or more of these dimensions, it is likely that an individual is not experiencing a sufficient level of well-being. . . .

ESSENTIAL DIMENSIONS OF WELL-BEING

. . . Our list contains six core dimensions: health, personal security, reasoning, respect, attachment, and self-determination. While we do not doubt that there are other theoretically appealing ways to specify the contents of the list, we think that the one we propose represents a useful set of criteria for illuminating the requirements of justice within public health and health policy and beyond. The discussion under each heading below elaborates our rationale for the inclusion of each as a separate category.

HEALTH

There are perhaps as many accounts of the concept of health as there are cultural traditions and healing professions. . . . [W]e work with what is essentially an ordinary-language understanding of physical and mental health that is intended to capture the dimension of human flourishing that is frequently expressed through the biological or organic functioning of the body. . . . [T]he absence of health refers to more than biological malfunctioning or impairments to some functional ability such as mobility, sight, or hearing. Being in pain, even if that pain does not impede proper biological functioning, is also incompatible with health. So, too, are sexual dysfunction and infertility. Health, so understood, thus reflects a moral concern with the rich and diverse set of considerations characteristic of public health and clinical medicine, including premature mortality and preventable morbidity, malnutrition, pain, loss of mobility, mental health, the biological basis of behavior, reproduction (and its control), and sexual functioning. . . .

Our approach to health . . . is quite different from the World Health Organization definition, which views health as a state of physical, mental, and social well-being (World Health Organization 1946). The problem with this otherwise noble aspiration is that it conflates virtually all elements of human development under a single rubric and thereby makes almost any deficit of well-being into a health deficit. . . .

Although health as a dimension of well-being is offered as the primary moral foundation for public health and health policy, there is no reason to suppose that every policy decision that bears on public health or medical care rests on the single moral foundation of health any more than any other intellectual discipline, profession, or social institution necessarily rests on a single moral foundation. For example, policies against female genital mutilation rest on concerns for health, the physical and psychological inviolability encompassed by the dimension we label as personal security, and self-determination. In this case, the moral foundation in justice for the policies draws upon three dimensions of well-being, none of which is reducible to the others. Each signals a separate kind of injustice produced through the mutilation.

The moral justification for health policies involving the distribution of medical services may depend as much on dimensions of well-being other than health as on health itself. For example, . . . society's obligation to ensure universal access to medical care rests not only on the effects of access on health but also on what justice requires with regard to what is necessary for being respected as a moral equal. . . . Accordingly, we argue that the concerns of any plausible theory of justice are multiple, and this plurality of concerns informs answers to questions about what justice in health policy requires.

In addition, the six general dimensions, which we put forward as a way of capturing and classifying the moral territory of social justice, are no substitute for more finely grained accounting of the many moral aspects *within* each dimension. This is perhaps particularly true of health, our primary concern, since policy makers often need to evaluate the justice of trade-offs among the various aspects of health. . . .

PERSONAL SECURITY

Many injustices involve harms to one's health, but they also involve so much more that is not reducible to the effect on health alone. Some injustices that involve

harms to health involve different, additionally salient harms to other dimensions of well-being. For example, an arm broken in an unsafe workplace differs from an arm broken while being tortured. Criminal acts such as rape or battery do more than harm the body. Assault (placing another in fear of imminent bodily harm) and intimidation are invasions of personal security, even when they do not eventuate in bodily injury or pain. It is arguably extremely difficult if not impossible to live a decent life if one is in constant fear of physical or psychological abuse. Experiencing such abuse is surely a setback to well-being, regardless of who we are or what values we might otherwise have. Violations such as rape, assault, and torture are of concern to the public health community because of their impact on health, but even more so they are the objects of concern for those persons and institutions having a special focus on human rights abuses, domestic violence, crime, war, and terrorism. . . .

REASONING

Reasoning is the name given to a broad set of diverse skills and abilities, including those classified within philosophical discussions since Aristotle under the headings of practical and theoretical reason. . . .

Theoretical reasoning abilities include the basic intellectual skills and habits of mind necessary for persons to understand the natural world. Such skills include analytical ability, imagination, the ability to form beliefs based on evidence, the ability to reflect on what counts as relevant evidence for those beliefs, and the ability to weigh the probative value of each. . . .

The nature and degree of theoretical reasoning skills and abilities needed, of course, vary in historical contexts. Literacy and numeracy are vital in complex industrial and postindustrial societies and perhaps less so in primitive agrarian or hunter-gatherer societies. Nonetheless, humans need some level of ability to reason deductively and inductively. They need the ability to make logical connections and detect logical errors; to measure, count, and perform other mathematical computations; to communicate effectively with others in a culture; and to make causal inferences. Like the other categories of well-being on our list, without them, whatever other dimensions of well-being we may have, we lack something crucial to our ability to function. . . .

Certain kinds of health states are necessary for reasoning, but they are not sufficient. What further distinguishes reasoning abilities from healthy functioning of the brain is that the former also require an understanding of the world that must be *learned.*

What is learned in the first few years of life has a profound affect on our abilities to reason across the life span. In part, the impact of learning in early childhood is mediated through the brain, whose continued development throughout childhood is influenced by environmental learning. Thus, reasoning abilities are affected not only by physical well-being during childhood but also by characteristics of the social world in which childhood is experienced. . . .

RESPECT

John Rawls and many others of widely differing philosophical emphases argue that respect is an essential element of human flourishing and that it is a proper concern of justice (Rawls 1971; Sen 1992; Nussbaum 2000; J. Cohen 1989; Anderson 1999). There are many ways of putting the point, and not all highlight precisely the same set of considerations. At minimum, respect for others involves treatment of others as dignified moral beings deserving of equal moral concern. Respect for others requires an ability to see others as independent sources of moral worth and dignity and to view others as appropriate objects of sympathetic identification.

Respect for others is closely linked to self-respect as well. A capacity for self-respect involves an individual's capacity to see oneself as the moral equal of others and as an independent source of moral claims based on one's own dignity and worth.

Respect then matters to human well-being in two related ways. A life lacking in the respect of others is seriously deficient in something crucial to well-being. So, too, is a life lacking self-respect. . . .

ATTACHMENT

The formation of bonds of attachment is one of the most central dimensions of human well-being. Such bonds include both friendship and love in their most intimate expressions, as well as a sense of solidarity or fellow-feeling with others within one's community. As the philosopher Martha Nussbaum observes (with reference to what she labels "affiliation"), such bonds matter for reasons of both friendship and justice. . . .

Empirical evidence suggests there is a tight link between the ability to form bonds of attachment between children and parents and between children and others known as "authoritative communities"

which are charged with the transmission of social values. When these attachments fail to take hold, the result is a lack of social connectedness that is exhibited in conduct disorders, lack of self-restraint, and antisocial levels of aggressiveness. . . . [R]espect alone is arguably lacking in the emotional depth that comes with a more robust attunement to the deepest needs and longings of others. Attachment is thus essential to justice in the same way that respect and reasoning ability are. . . .

SELF-DETERMINATION

The value of self-determination, the linchpin of liberal political theory, is a broad and encompassing category of human good. It is widely endorsed in many moral and political systems, even among those who complain that in specific cultures or concrete cases too much concern is placed on individual choices. The value of self-determination underlies many accounts of the importance of political liberty, and as we shall claim, it is a foundation for other conclusions about what a just social structure requires. . . .

Imagine a life in which the other essential dimensions of well-being are present. A person is healthy, has strong bonds of attachment, is self-respecting and enjoys the respect of others, is secure in his person, and has developed capacities for reasoning. However, from his earliest years onward, this person has been told what his path in life will be. All the elements of his life have been determined for him, including how much and what kind of schooling he will have, how he will make a living, with whom he will be friends, where he will live, whether he will have children and how, and so on. Although his life in many ways goes well, he has been denied any opportunity to shape its contours through his own choices and thus has been denied the chance to make something of his life through his own efforts. Such a life would be rich in all other respects but seriously lacking in what is required for a decent life. . . .

The successful exercise of self-determination, like the successful navigation of the helmsman, will depend also on the favorable circumstances in which other dimensions of well-being, health, personal security, attachment, respect and the exercise of reason, are present in sufficient quantity. . . . [E]ach dimension is such that a life substantially lacking in any one of these is a life seriously deficient in what it is reasonable for anyone to want, whatever else they want. Each is thus a separate indicator of a decent life which it is the job of justice to facilitate. . . .

CAPABILITIES, FUNCTIONING, AND WELL-BEING

Our theory of justice has many affinities with and owes a considerable intellectual debt to capabilities theories as developed by Amartya Sen and Martha Nussbaum. However, for a variety of reasons we prefer a somewhat different terminology and reach some considerably different conclusions about how best to characterize the central interests in human well-being. . . .

There is a crucial ambiguity between functioning and capability that has led to some measure of confusion. For many of the dimensions of well-being on our list, a central concern is for certain desirable states—being secure in our person, being healthy, being respected, and being a self-determining person. It is a stretch of language to describe them all as functionings, for example, in the case of health. . . . We think it is better to simply note that there are distinct dimensions of well-being and that, for each dimension, a part of its value lies in what states are achieved and another part often consists in our active role in bringing the states about. . . .

Sen elsewhere notes that "the central feature of well-being is the ability to achieve valuable functionings" (Sen 1985, 200). Martha Nussbaum also endorses this general conclusion, noting that the state (the city-state in Aristotle's theory) "aims at enabling people to live well" and that the "goal is a certain sort of capability—the capability to function well if one so chooses" (Nussbaum 1988, 160).

We think that even for adults, these generalizations are unwarranted, at least for the dimensions of well-being we take to be central to justice. Even for adults, our active participation in bringing about our own well-being is not definitive of our well-being. Well-being consists of being in some state or condition, such as being healthy, being respected, or leading a self-determining life. Being healthy matters to our well-being whether or not that state is achieved by our action or by the action, say, of governmental bodies that secure for us potable water. . . .

[T]he reason that our theory attends to the various elements of the social structure causally related to the development and preservation of each dimension of well-being is that such information is relevant to answering questions about which inequalities are most urgent to address. Consider two illustrative examples of when inequalities instrumentally relevant to

well-being may be more urgent. One case involves circumstances in which the combined effect of two social determinants is a magnification of the adverse effects on a dimension of well-being. Neighborhoods or countries lacking proper sanitation, coupled with lack of basic primary preventive care, including the necessary immunizations, can increase both the probability and severity of communicable diseases among a population. . . .

Overlapping social determinants affecting a particular dimension of well-being, therefore, raise matters of special moral urgency when they form a constellation of inequalities that systematically magnify and reinforce the initial adverse effects. . . .

The simplest example of clusters of effects flowing from a single social determinant involves institutions and social conventions designed primarily to affect one dimension of well-being, but which simultaneously have profound and pervasive effects on other dimensions of well-being as well. For example, the effect upon health alone is not the sole criterion on our view for evaluating the justice and injustice of a health care system or public health policy. That such systems or policies result in substandard health for some is a major ground for moral concern, but so too is the impact of those systems and policies on capacities for respect for self and others, self-determination, and the ability to form bonds of attachment. . . . In these instances, clusters of effects are produced in tandem as a direct result of the design and structure of a catalytic social determinant affecting multiple dimensions of well-being simultaneously. . . .

The point is that justice, in a well-being sufficiency theory, can be achieved under such conditions either by lessening the differences in wealth and income or by lessening what can be done with wealth and income, for example, with regard to such things as financing political campaigns and causes, buying organs for transplant, and gaining entrance to elite educational institutions. If, however, circumstances are such that wealth inevitably determines how each person fares with respect to the social basis of some dimensions of well-being, then differentials in wealth and income are unjust because they cause some to fall below levels of sufficiency for multiple dimensions of well-being. . . .

There are notable examples from the social science literature on the way educational deficits and poor health display this pattern of cascading and interactive effects. Deprivations of reasoning abilities cannot help but spill over and cause or reinforce deprivations in health. Equally consequential for the prospects of developing one's reasoning capacities are deprivations in health. . . . [T]he approach described here is an interactive model, not simply a linear model in which one single causal sequence all the way down the line is assumed. The development of each dimension of well-being provides both opportunities for and constraints on the development of the other dimensions of well-being. Poor health is not just added to poor reasoning abilities. Each can be made worse by the presence of the other. Poor education not only leads to the underdevelopment of reasoning capacities but also plays a further, well-documented role in producing poor health. Not only does lack of access to health care for children undermine children's health, but the conventional public acceptance of their widespread exclusion from access to care also can adversely affect capacities for respect and affiliation for both parents and children.

There are thus instances in which social structures can compound the adverse effects on well-being in all its dimensions and mutually reinforce the probability of their production. A cascade of deprivations greater in their magnitude than each would have been in isolation is set in motion. Inequalities in such social structures are among those most urgent to address. They thus warrant a heightened level of moral scrutiny on our theory.

The phenomenon of interactive and cascading effects has some interesting implications for how we answer questions about which inequalities are most urgent to address. . . . Justice demands attention to all the dimensions of well-being. But the cascading and interactive causal model adds a twist to this logic. In some cases, it is conceivable that sufficiency of some dimensions of well-being (e.g., health) may be promoted best by attention to other dimensions (e.g., reasoning development). In such cases, the answer to which inequalities are most urgent to address may be that we should give priority to addressing inequalities in those social determinants in which the potential adverse effects on more dimensions of well-being are at stake. No simple algorithm is possible, but some additional moral guidance for public policy arises out of an awareness of how the various dimensions of well-being and the social determinants affecting them can interact. . . .

DENSELY WOVEN, SYSTEMATIC PATTERNS OF DISADVANTAGE

. . . In many cases, however, the inequalities that arise are not simply the consequence of unrelated instances of bad luck; they are predictable consequences of some forms of social organization that are within the power of human agency to alter. Some are likely to miss every train as a consequence of the way basic social structure is arranged. . . . The causes and effects in such situations are structural and systematic: they are artifacts of the interactive workings of the overall social structure, and the pattern of advantages and disadvantages that emerge are often the consequences of activities of numerous overlapping institutions, social practices, and individuals. . . .

One source of disadvantage, such as inequality of economic resources, can create and exacerbate deficiencies in several, if not all, dimensions of well-being. Adverse effects on any dimension of well-being can have spillover effects on other dimensions of well-being and set a cascading and interactive causal chain in motion. Poor reasoning development can contribute to poor health and vice versa. Well-being deficiencies of one sort can fuel inequalities in the social basis of other dimensions of well-being. . . .

One prominent form of systemic disadvantage is variously labeled as oppression, group domination, or subordination. Whatever the label, this particular pattern of systematic disadvantage is linked to group membership. Perhaps the most acute and most visibly manifested instances of that phenomenon are exhibited in racism, sexism, and ethnic conflict. Such patterns typically involve (*a*) lesser respect accorded to some persons because they are members of an identifiable group; (*b*) which often translates into lower respect for self and a reduced sense of personal efficacy and capacity for self-determination among members of the lower status group; and (*c*) members of higher status groups benefit (or believe they benefit) from a social arrangement in which members of subordinated groups are held in lower regard (Cudd 1994; Young 1990).

Domination or oppression based on shared characteristics of a group have some features in common with other forms of systematic disadvantage. Wealth, power, and opportunities may be concentrated in the hands of a few. Domination can take many forms, including political dominance, cultural dominance, intellectual dominance, market dominance, or any number of other ways in which the life prospects of some are profoundly diminished, often by virtue of the better life prospects of others within a society. . . .

Our life course model reflects the notion that much of the way our prospects are dominated by social structural conditions is not simply a matter of lack of more or better choices, but of constraints that guarantee diminished futures from an early age. Dimensions of well-being, therefore, are not reducible to what mature, autonomous, self-interested adults can choose; they refer also to the underlying unchosen conditions that determine the extent to which we are able to flourish. . . .

[W]e find much affinity with Hume's observations on justice. As we see it, the job of justice in its most pressing role demands a permanent vigilance and attention to social and economic determinants that compound and reinforce insufficiencies in a number of dimensions of well-being. For the most part, their importance is tied to a careful empirical appraisal of social institutions as a whole and their potential for profound and pervasive effects on those dimensions of well-being. What may be required by our approach is, therefore, dependent on contingent and shifting constellations of human vulnerabilities rising and falling in significance under particular forms of social organization. . . .

PUBLIC HEALTH, THE NEGATIVE POINT OF JUSTICE, AND SYSTEMATIC DISADVANTAGE

. . . [I]nequalities in health that are a part of such systematic patterns of disadvantage are the inequalities that are most morally urgent to address. Justice here demands aggressive public health intervention to document and help remedy existing patterns of systematic disadvantage and their detrimental consequences. . . .

One important implication of our theory is that whether any particular inequality in health is among those most morally pressing to address requires consideration of both how the people affected are faring with respect to the rest of their lives as well as how any public health interventions interact with other dimensions of well-being. . . .

Disadvantaged Social Groups: Disparities in health statistics take on different moral meaning when those disparities identify differences between socially dominant groups and socially disadvantaged groups. . . . [P]atterns of systematic disadvantage linked to group membership are among the most invidious, thorough going, and difficult to escape. They generally engage

all the dimensions of well-being, but perhaps most centrally the dimension of respect. Group membership becomes sufficient reason for failing to treat people as dignified human beings worthy of equal moral concern. . . .

One critical moral function of public health as we see it is to monitor the health of those who are experiencing systematic disadvantage as a function of group membership, to be vigilant for evidence of inequalities relative to those in privileged social groups, and to intervene to reduce these inequalities insofar as possible. . . .

One of the most compelling recent examples of work in public health on behalf of an oppressed group involved documentation of the disastrous impact of the Taliban rule on the health of women. Research conducted by the group Physicians for Human Rights provides powerful evidence that the denial of basic human rights to women resulted not only in horrible injustices with regard to respect, affiliation, and personal security, but also with regard to health (Rasekh et al. 1998). It is not necessary, however, to point to the horror of the Taliban regime to find examples of public health research documenting the impact of oppression of women upon their health. In the developing world, as well as in some communities in the United States, the vulnerability of women to HIV is attributed in large measure to women's lack of political and social status and their dependence on men (Gollub 1999; Sanders-Phillips 2002; Buseh et al. 2002; Wyohannes 1996). Public health research has also helped direct the world's attention to the impact of violence against women on women's health (Pan American Health Organization 2003), as well as to the enormous health problems of many indigenous peoples (Pande and Yazbeck 2003; Wiseman and Jan 2000; Roubideaux 2002).

In American public health, much attention has been paid to disparities in health between white Americans and nonwhite Americans, particularly African Americans, Native Americans, and Hispanics. The implicit assumption, which we believe to be correct, is that these disparities are of particular moral concern. . . . [F]rom the standpoint of our theory of social justice, it is not necessary to establish a direct causal connection between specific health disparities and specific acts of injustice, such as overt discrimination in access to advanced medical technology or primary health care, to hold that these inequalities are of significant moral urgency. Nor are we arguing that addressing these inequalities is of significant moral urgency as a matter of compensation for some kind of "trans-generational debt" (Loury 2002; 2003, 337). Rather, we maintain, in line with the work of Glenn Loury, that social and cultural factors that have historical roots but that remain persistent have resulted in continuing disparities in human development and flourishing. Combating overt racism and racial discrimination, although important to root out where they exist, is not sufficient to addressing this gap in well-being. Thus, for us, a different kind of causal story is required, a causal story about how a disadvantaged group's staying in relatively poorer health continues to contribute to decreased well-being overall. . . .

Poverty and Disadvantage: . . . [I]nequalities in well-being associated with severe poverty are inequalities of particular moral urgency. Those who have a proportionately tiny share of available economic resources are worse off, not simply by virtue of having a much reduced standard of living, but in having disproportionately little influence on public affairs and in the marketplace, all of which translates into their having little control over their own lives. . . . [S]ystematic patterns of disadvantage that flow from dramatic differences in material resources produce a cluster of deficiencies in well-being that makes it extremely unlikely that individuals can improve their life prospects through their own efforts. . . .

With regard to the dimension of health, perhaps the starkest indicator of the inability of all to walk the same path is found in differentials in life expectancy. Here, we live in a world of radical inequality (Pogge 1998). Despite significant improvements in life expectancy in low-income countries since 1960 (Jha et al. 2002), there is currently as much as a forty-year differential in average life expectancy between those who live in major industrial countries and those who live in southern Africa. Even if mortality in early childhood is not considered (a topic we will address shortly), in 2000, the average fifteen-year-old boy living in the United States can expect to live well into his seventies, if not beyond, while the average fifteen-year-old boy living in Uganda will be lucky to reach his fiftieth birthday. With life prospects, indeed the very prospect of living at all, so radically different, it is hard to conceive of these two youths as in any respect walking the same path. The magnitude of this source of extraordinary injustice cannot be overstated. It is estimated that each year as many as twenty million people in severe poverty in the developing world die

young, by the standards of the rest of the world, from malnutrition and diseases that can be inexpensively prevented or treated. . . .

Children: . . . As a developmental matter, unless children experience a state of sufficient well-being in their young years, their capabilities as adults, and thus what they will be able to do with their lives, will be compromised. We are concerned about the actual health, reasoning abilities, and attachment of children, in part because these dimensions of well-being will develop properly, if at all, only if they are nurtured and secured in appropriate developmental stages. . . .

Perhaps the most obvious way in which compromised health in childhood forecloses options in adulthood is through child mortality. Despite significant reductions in child mortality in the 1980s and early 1990s, in 2003 more than 10 million children under the age of five years died (Gillespie et al. 2003). Almost all of these children lived in low-income countries or in poor communities in middle-income countries. Most of these deaths could have been prevented by interventions that in 2003 were available, reasonably cheap, and in widespread use (Jones et al. 2003). By any plausible account of social justice, and certainly by our own, these deaths constitute injustices of the gravest sort (Victora et al. 2003). Diarrhea, pneumonia, and malaria—the principal killers of young children, abetted by undernutrition—are all eminently treatable or preventable conditions. Among the world's poorest, many children never survive long enough for us to even begin to speak meaningfully about their capabilities, well-being, or flourishing. . . .

PUBLIC HEALTH, THE POSITIVE POINT OF JUSTICE, AND HEALTH INEQUALITIES

As we see it, the job of justice in its most pressing role looks first to conditions of the most profound disadvantage. Justice's first concern requires permanent vigilance and attention to determinants that compound and reinforce insufficiencies across multiple dimensions of well-being in ways that make it difficult if not impossible to escape. Although our theory thus concentrates the attention of public health on those gaps in well-being that are the most urgent, there is a positive as well as a negative point to our theory, one that sets aspirations for achieving a sufficient level of well-being in all of its essential dimensions for everyone. For the dimension of health, it is not possible to specify with precision what sufficiency requires, nor is it possible to establish precise numerical targets. At an outer bound, sufficiency can be pegged to what is technologically feasible with regard to both length and health-related quality of life. The World Health Organization's Burden of Disease projects, for example, use the world's longest life expectancy, that of the Japanese, as the benchmark for measuring health burdens internationally. A less demanding account of sufficiency would require that each of us have enough health over a long enough life span to live a decent life. . . .

Note that all of our judgments about the relative urgency of inequalities in health and their relationship to the negative and positive points of justice, reflect not only the particular commitments of our theory but also the empirical particulars in which these inequalities occur. As relevant features of the world change, so too do the implications for justice and public health. While the positive aspiration of public health—to strive for all lives that are healthy and long—remains a constant, what it is possible to obtain in terms of health is ever changing. So too are the concrete demands of the negative aim of our theory for public health. Here also the moral job of public health remains constant: to document and help remedy existing patterns of disadvantage and their detrimental effects and to ensure that children achieve sufficient levels of health so that well-being in adulthood is possible. However, as patterns of social organization and systematic disadvantage alter and the greatest threats to health sufficiency and other dimensions of well-being shift, the specific moral priorities for public health also will shift. And that is as it should be.

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