Distributive Justice

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Distributive justice refers to the moral principles that guide the distribution of benefits and burdens in society. Distributive justice is grounded in the principles of social justice. In healthcare contexts, distributive justice offers "moral directives to a just allocation of resources, fair compensation to providers, and a reasonable range of services" (Dharamsi & MacEntee, 2002, p. 325). Distributive justice has become an underlying principle in health policies and healthcare reforms around the world. Recognizing the historical injustice and inherent disparities faced by marginalized and vulnerable populations, distributive justice emphasizes that justice can be achieved by modifying how a community distributes its resources/benefits and burdens/costs. However, distributive justice can be complicated in practice.

Three primary approaches to distributive justice are libertarianism, egalitarianism, and contractarianism. A *libertarianism* approach believes that freedom of choice (e.g., freedom to choose without government interference) should be the guiding principle. Because libertarianism emphasizes individual liberty, such ethical principles can motivate individuals and governments to resist mandatory health practices (e.g., mandatory childhood vaccination or wearing a facemask during the COVID-19 pandemic) as such mandates strip individuals' freedom of choice. Under libertarianism principles, many governments have allowed their citizens to claim nonmedical exemptions, including religious and personal belief exemptions, to mandatory childhood vaccination despite the potential to jeopardize the health of local communities. Recent studies consistently found that in Europe and the United States, nonmedical exemptions have increased over the last two decades and are highly prevalent in places where such claims are easily granted. In places where nonmedical exemptions are readily available, there are increased risks of vaccine-preventable diseases, such as pertussis and measles outbreaks.

Due to the concerns about undue harm to others and negative implications to public health, some scholars have argued that *libertarian paternalism* (i.e., nudging – gently helping people to make better choices) may be an ethically justified approach to health intervention (Ménard, 2010). For example, rather than eliminating nonmedical exemptions, governments can utilize complex procedures and increase barriers to reduce individuals' likelihood to claim nonmedical exemptions. While there are concerns about whether the paternalistic approach to public health interventions truly protects individual liberty, scholars have noted that interests in public goods and deliberative procedures (e.g., allowing *all* members in a community to voice their perspectives) can generate sufficient safeguard to protect individual liberty and public health. From this

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perspective, the increasing emphasis of community-based participatory research and health interventions (e.g., culture-centered and Integral Fusion approaches) reflects the recent trends in protecting individual interests in health interventions.

An *egalitarianism* approach argues that every person should have an equal claim on all available resources. In contrast, a *contractarianism* approach believes that because social inequalities are unavoidable and inherent in our social worlds, people hold a social contract with one another to create a moral imperative to distribute basic needs to each other (the population) in a fair and unbiased manner that is responsive to such inequalities (i.e., the least advantaged should receive the greatest benefits; Rawls, 1971/2009). In other words, people make concessions to others' needs not because they must do so (e.g., as a moral imperative or to break an impasse) but because "they (ethically) should do so by virtue of living in a community with others" (Roemer, 1998, p. 93).

Equality (i.e., every person is entitled to an equal share) is easy to measure (e.g., whether one person's share is equal to another's). Hochschild (1981) noted, "Aristotle's dictum 'treat equals equally' is useless until we specify who is equal to whom, what goods are subject to the dictum, and what equal treatment means in a particular case" (p. 51). Rather than focusing on the equal amount of resource distribution, both adults and children appeared to be more sensitive about the fairness of resource distribution. An Australian study found a strong egalitarian attitude among its participants (e.g., very little support to distribute lifesaving health sources for young people over the elderly; Nord et al., 1995). Equality is a common value embraced by Americans (Hochschild, 1981). It is also an essential value in guiding healthcare reforms in the United States (Braveman et al., 2011).

The primary focus of equality centers on a measurable quantity of distribution. In health contexts, equality generally translates into individuals having equal opportunity to access health resources rather than having equal health status/outcomes. The resources needed to be healthy (i.e., the determinants of health, including living and working conditions necessary for health, as well as medical care) should be distributed fairly (as opposed to equally) regardless of the patients' age, race, gender, or social influence (Braveman et al., 2011). In contrast to libertarianism's resistance to government interventions, a survey of 29 countries found that people who hold egalitarian attitudes are more likely to support government intervention for healthcare provision (Azar et al., 2018). This is because without governmental interventions and institutional policies, people who are wealthy or are powerful are likely to gain priority in obtaining resources (e.g., the waiting list for organ transplants or COVID-19 vaccine).

In places with strong egalitarian attitudes, there is limited public support for health policies that maximize the benefit to the public at the expense of loss of equity and access to service for marginalized and vulnerable populations. A person's strong egalitarian belief predicts positive attitudes toward noncitizens, including supporting policies that offer noncitizens access to publicly funded healthcare (Sun et al., 2015). The health impact of individuals' social capital (i.e., the availability of social support through one's social networks) is greater in less egalitarian countries than in egalitarian countries. In other words, in egalitarian societies, individuals' quality of care (e.g., healthcare access,

process and outcomes) is protected through infrastructure and social policies and is not dependent on one's support networks or resources.

However, social institutions may intentionally establish discriminatory policies and structural barriers to protect scarce resources. Proponents of *luck egalitarianism* argue that individuals who are responsible for their needs should be given lower priority when the resource is scarce. Studies suggest that under luck egalitarianism, individuals and societies may find it appropriate to limit healthcare resources to patients who are perceived to contribute to their own illness conditions (e.g., drug users with hepatitis C, gay people with HIV+, and individuals with alcohol-related end-stage liver disease). Because attribution of personal responsibilities to illness conditions is often political in nature, marginalized populations can be particularly vulnerable and unfairly burdened under the egalitarian principles. In short, equality is insufficient to make good social policies particularly when the resources are scarce.

Healthcare resources are often scarce, resulting in different groups of people competing for the same, limited resources. Following the principles of contractarianism, health equity aims to provide solutions while addressing existing inequalities. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities. Health equity is "the value underlying a commitment to reduce and ultimately eliminate health disparities" (Braveman et al., 2011, p. S151). From this perspective, health equity follows a contractarianism approach – highlighting our moral duty to eliminate disparities faced by the Other (e.g., marginalized populations) by distributing higher levels of benefits (e.g., social welfare) to the disadvantaged members of our community. Under a contractarianism approach, a society recognizes that a person is not truly free to choose any community or society one wants (e.g., we are born into our family with no choice of our race or sex) and that inequality is an unavoidable social condition. Thus, members of a community have a moral duty to cooperate with one another – recognizing that when the least advantaged members of a community get more resources, the society benefits as a whole from one generation to the next (Rawls, 1971/2009). Some scholars have argued that rather than conceptualizing universal healthcare access as a right of individuals, the public may be more receptive to recognize universal access to healthcare as an obligation of government through contractarianism principles.

SEE ALSO: Community-based Participatory Research; Culture-centered Approach; Health Disparities: Access; Health Disparities: African American; Health Disparities: Asian American; Health Disparities: Indigenous: Africa; Health Disparities: Indigenous: Americas; Health Disparities: Indigenous: Asia; Health Disparities: Indigenous: Native American; Health Disparities: Indigenous: Oceania; Health Disparities: Latinx; Health Justice.

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Further reading

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