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# Introduction

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Impressive gains in average life expectancy have been achieved worldwide in the second half of the twentieth century. These gains have been attributed to a variety of socio-economic factors and public policies, and—to a lesser extent—to improved medical care. The changes in life expectancy, however, have not been distributed equally either among or within countries. Among countries, there have been advances in many, but some countries—especially in sub-Saharan Africa and the former Soviet Union—have seen reversals in life expectancy (United Nations Development Programme 2003: 262–5). Within countries, some social groups have benefited significantly but the health status of others has stagnated or worsened. Very large disparities in life expectancy are found within countries across different social groups and regions.<sup>1</sup> Thus, although average life expectancy worldwide has increased significantly, inequalities in health remain a matter of deep concern.

Research on the health status of populations and population subgroups has a long history in public health. The relationship between poverty and ill-health, in particular, has been recognised centuries ago. In contemporary public health research, poverty is still treated as a major factor behind health inequalities within and between countries<sup>2</sup>, but it is becoming increasingly evident that significant inequalities exist even in the absence of (absolute) material deprivation and in countries that have universal access to health care (see Chapter 3 by Marmot, this volume).

Current research on social inequalities in health—differences in health outcomes between social groups defined by variables such as class, race, gender, and geographical location—has been much influenced by the publication of two reports in the United Kingdom around 1980. One was the Black Report, which documented extensive health inequalities among socio-economic groups in Britain (Black and Morris 1992 [1980]). The second was a study by Michael Marmot and his collaborators (the Whitehall study), which

<sup>1</sup> For example, see the US ethnic- and county-level estimates of life expectancy in Murray et al. (1998).

<sup>2</sup> For example, in cross-country regressions of life expectancy, Anand and Ravallion (1993) find that (absolute) income poverty is a very significant explanatory variable.

found that among British civil servants there is a significant inverse relationship between employment grade and mortality rate—the higher the grade, the lower the mortality rate (Marmot et al. 1978). A huge literature has since spawned on this question in many countries, which systematically documents inequalities in health across social groups.<sup>3</sup>

Concern with health inequalities has figured on the policy agenda—international and national—for some decades. Implicit recognition of the importance of health inequalities led to the World Health Organization (WHO) ‘Health for All’ initiative—proclaimed in Alma Ata in 1978 (World Health Organization 1978). During the 1980s and 1990s, however, the policy discourse continued to emphasise aggregate population health. Given the mounting evidence of stagnation—and sometimes deterioration—in the health status of many population groups, a renewed interest in health inequalities has begun to emerge.

The current concern with health equity emphasises that health is influenced by a wide range of social circumstances and public policies, and not just by access to health care and traditional health-sector policies. Within the discipline of public health, there is growing appeal to the social sciences and a move towards more interdisciplinary analysis of the social processes underlying inequalities in health. This development is often labelled the *new public health*, but as Ann Robertson (1998: 1419) stresses, ‘[m]any would argue that this is not so much a new public health as a return to the historical commitments of public health to social justice’.<sup>4</sup>

This commitment of public health to social justice and to health equity raises a series of ethical issues which, until recently, have received insufficient attention. Why, if at all, should a concern with health equity be singled out from the pursuit of social justice in general? Can existing theories of justice provide an adequate account of health equity, or is there a need to rethink what is unjust about inequalities in health? What is the extent of social—as opposed to individual—responsibility for health? What ethical problems arise in evaluating population health and health inequalities, and what are appropriate criteria to do so? How should universal aspirations be balanced with contextual considerations in the evaluation of health and health equity?

These are some of the important questions that need to be addressed in understanding the foundations of health equity. The extensive empirical and policy research on health and health inequalities has yet to be matched by an appreciation of the normative underpinnings of health equity. Philosophers and applied ethicists have tended to remain silent on the topic of health

<sup>3</sup> Chapters 3 and 4 in this volume by Marmot and Daniels et al., respectively, provide good summaries of this research.

<sup>4</sup> On this, see also Mann (1995) and Krieger and Birn (1998).

inequalities. John Rawls's theory of 'justice as fairness', for example, avoids any discussion of health.<sup>5</sup> Insofar as the topic of health equity is addressed at all, the focus has been restricted to access to *health care* (Daniels 1985). In this respect Charles Fried's (1975) argument that a right to health can only imply a right to health care was very influential (Marchand et al. 1998). Similarly, *bioethics* has tended to focus on medicine and individual life-and-death questions, but has neglected the variety of social forces that influence health. Access to medical care is certainly an important factor in the preservation and restoration of health and is one element in assessing health equity, but by no means the only one.

According to Daniel Wikler (1997) bioethics is now ready to move to a new phase and address the issues raised by the empirical literature on social inequalities in health. Indeed, over the past few years, several publications have appeared which deal with what may be called public-health ethics (Marchand et al. 1998; Beauchamp and Steinbock 1999; Daniels et al. 2000; Danis et al. 2002).

The present volume was conceived as an attempt to initiate this important subject area. It has been our aim to launch a wide investigation of the ethical issues underlying inequalities in health. In order to examine health equity from a variety of perspectives, contributions have been solicited from philosophers, anthropologists, economists, and public-health specialists. The contributions centre on five major themes: (1) what is health equity?; (2) health equity and its relation to social justice; (3) health inequalities and responsibilities for health; (4) ethical issues in health evaluation and prioritisation; and (5) anthropological perspectives on health equity.

## HEALTH EQUITY

The two chapters in this part provide an introduction to health equity. Many of the issues raised in these chapters are subsequently addressed elsewhere in the volume. In Chapter 1 Sudhir Anand starts by asking the following questions: why are we concerned with health equity and what is its relation to equity in general? Should we be more concerned about inequalities in health than about inequalities in other dimensions such as income? Should we be more concerned with some types of health inequalities than with others? Should we be less tolerant of inequalities across certain population groups than across others? He argues that health should be treated as a special good

<sup>5</sup> '[S]ince the fundamental problem of justice concerns the relations among those who are full and active participants in society... it is reasonable to assume that everyone has physical needs and psychological capacities within some normal range' (Rawls 1993: 272*n*).

because it is a prerequisite to a person functioning as an agent. Inequalities in health thus constitute inequalities in people's capability to function—a denial of equality of opportunity.

Chapter 2 by Amartya Sen provides a multidimensional framework for investigating health equity. According to him, 'health equity is a broad and inclusive discipline', which consists of many aspects. It is concerned not only with equity in the dimensions of health care and health outcomes, but with broader considerations of social justice which have a bearing on health. The capability approach developed by Sen lends itself well to illuminate these different aspects of health equity. He further emphasises the distinction between outcome-related evaluation and process-related evaluation. In contrast to those who conceive of health equity as primarily an outcome-based concept, Sen emphasises the importance of procedural considerations such as nondiscrimination in the pursuit of equality of health outcomes and in the delivery of health care.

### HEALTH, SOCIETY, AND JUSTICE

Chapter 3 by Michael Marmot provides an excellent introduction to the issues raised by research on social inequalities in health. It draws on his famous 'Whitehall' studies of British civil servants (Marmot et al. 1978, 1991) and similar studies, which show that health is positively correlated with socio-economic status. In his chapter, Marmot discusses why social gradients in health outcomes should be a matter of policy concern. He then critically examines a variety of explanations that have been offered for the occurrence of social inequalities in health. Marmot argues that the most promising approaches are those that attempt to uncover the social causes and pathways underlying differences in health outcomes between social groups.

In commenting on the observed correlation between social position and health, he questions explanations which give prominence to reverse causation (or 'endogeneity'). In particular, he rejects the 'health selection' argument, according to which social inequalities in health arise not because of social influences on health, but because individuals or families with a disposition to poor health are economically less successful and end up in the lower socio-economic groups.

The main thrust of Marmot's chapter is to emphasise the role of social factors in the production of ill-health and to underscore the need for policies that address these factors. He shows that even for those disparities in health that may be linked to individual lifestyle choices such as smoking, a social gradient in health outcomes remains after controlling for these choices. Hence such individual choices do not, according to Marmot, undermine the case for interventions to correct inequalities in health. In a later chapter, Daniel Wikler also discusses the extent to which society's obligation to correct inequalities in health is diminished by individual lifestyle choices, and concludes that responsibility for health cannot reside solely with the individual.

In Chapter 4 Norman Daniels, Bruce Kennedy, and Ichiro Kawachi take the same starting point as Marmot, *viz.*, the observation of a social gradient in health outcomes. They seek to answer the question ‘When are social inequalities in health unjust?’, and argue that the Rawlsian conception of justice is applicable in this context. Their argument draws on an extension of Rawls’s theory of justice developed by Daniels (1985) in the context of just health care. He invoked the Rawlsian principle of ‘fair equality of opportunity’ and broadened the definition of opportunity to include health. While Daniels (1985) saw health as being determined by health care, Chapter 4 by Daniels *et al.* recognises that there are many factors other than health care which affect a person’s health. In consequence, they extend Rawls’s principle of fair equality of opportunity to the entire range of factors that influence health.

Although this argument would seem to be a sufficient foundation for health equity, Daniels *et al.* introduce another reading of the relationship between Rawlsian justice and health equity. This approach brings to bear the entire edifice of ‘justice as fairness’ as developed by Rawls (1971). The first principle of justice requires equality of basic rights and liberties. The second principle consists of the subprinciples of ‘fair equality of opportunity’ and the ‘difference principle’. These principles are applied by Rawls to the distribution of ‘primary goods’, which Daniels *et al.* claim happen to be coterminous with the social determinants of health. Thus, they argue that the application of Rawls’s principles of justice will automatically solve the problem of social inequalities in health.<sup>6</sup> As expressed in the title of their chapter, they conclude that a just society ‘is good for our health’.

Like the previous two chapters, Chapter 5 by Fabienne Peter also takes as its starting point the empirical findings of social inequalities in health, and examines how these relate to normative judgements about health equity. Her approach, an indirect one, embeds judgements about health equity within the pursuit of social justice generally. Most existing approaches to health equity are what she calls ‘direct’: they treat health as a special good and identify principles that should rule its distribution. An example is the application in Chapter 4 by Daniels *et al.* of Rawls’s principle of fair equality of opportunity. According to Peter’s ‘indirect’ approach, social inequalities in health are unjust when they are the result of injustices in the basic structure of society in Rawls’s sense. This relationship explains why we are particularly concerned with certain inequalities in health—for example, those between the rich and the poor—and not with others. Conversely, knowledge of particular inequalities in health can be used to reveal how the basic structure of society is working, and thus inform judgements about social justice.

<sup>6</sup> See the commentary by Anand and Peter (2000) on the possible tension involved in simultaneously invoking both views of how Rawlsian justice might apply in dealing with health equity.

**RESPONSIBILITY FOR HEALTH AND HEALTH CARE**

Rawls's theory of justice has been criticised for neglecting the distinction between situations in which individuals carry no responsibility and situations where they do. As it is sometimes argued that social inequalities in health arise from health-compromising individual behaviours, it is important to scrutinise the moral relevance of personal responsibility. In Chapter 6, Daniel Wikler concedes that individual responsibility matters, but rejects the conclusion that this absolves society from an obligation to correct social inequalities in health. Wikler points out that health gradients exist independently of behavioural patterns. And even if health outcomes do vary with behaviour, he argues that it is difficult to establish whether the actions have been taken through free will—a necessary condition for attributing moral responsibility. Wikler concludes that personal responsibility for health should not be assigned more than a peripheral role in health equity.

Chapter 7 by Thomas Pogge discusses the theoretical question of how justice gives rise to social responsibility for health. He distinguishes between conceptions of justice that focus on 'distributional' factors and those that focus on 'relational' factors. Pogge argues that most existing conceptions of justice are of the distributional type, where judgements of justice and equity are concerned with bringing about a 'good distribution' of some entity that is judged to be morally relevant—for example, health. A relational conception of justice assesses not merely the outcomes but also the extent to which our actions are responsible for the outcomes. The more we are responsible for an outcome—the stronger the causal relation between our actions and the harms suffered—the stronger our obligation to help or intervene.

In the case of health, a relational perspective is concerned with more than a good distribution of health outcomes. Judgements of health equity must be concerned with an evaluation of the responsibility of agents in the production of health.<sup>7</sup> The stronger our involvement in bringing about adverse health outcomes, the greater our obligation to redress them. According to Pogge, such an evaluation—and our obligations—should not be confined to national boundaries.

Chapter 8 by Philippe Van Parijs is concerned with obligations for health care across regional boundaries. He discusses the case of Belgium, where the two main linguistic groups (the Flemish and the Walloon) are at odds over the allocation of the country's health-care resources. The per capita consumption of publicly-funded health care is significantly higher in Wallonia than in Flanders, which is economically better off, and the Flemish have objected to subsidising the Walloon's health-care expenses. For Van Parijs, this conflict raises the more general issue of what the requirements of justice should be between the two groups, or 'peoples'. His proposed solution draws on

<sup>7</sup> In contrast to Wikler's view, Pogge's line of reasoning would seem to imply a greater role for individual responsibility in judgements of health equity.

Rawls's *Law of Peoples* (1999), but is more demanding. Van Parijs rejects a dualist approach, with two largely independent systems and minimal transfers. Instead, he argues that we should avoid making 'a sharp dichotomy between solidarity within one people and solidarity across peoples' (p. 179, this volume).

## ETHICAL AND MEASUREMENT PROBLEMS IN HEALTH EVALUATION

The fourth part of the volume is concerned with ethical and measurement problems in health evaluation. How should we aggregate health across people, time, and different types of health condition? What ethical problems arise with existing measures of population health and of the burden of disease? What are the consequences of using cost-effectiveness analysis for evaluating health interventions? What problems arise in incorporating longevity in the valuation of health at a point in time? These are some of the questions addressed in this part of the volume.

Most of the chapters focus on the 'disability-adjusted life year' (DALY), a measure adopted by the World Health Organization and the World Bank, and related metrics such as the quality-adjusted life year (QALY). Chapter 9 by Sudhir Anand and Kara Hanson and Chapter 10 by Dan Brock discuss a number of ethical problems with the use of DALYs and QALYs. They draw attention to questionable assumptions underlying these metrics—for example, concerning age-weighting and discounting future life in DALYs—and to the limitations of cost-effectiveness analysis in priority setting.

Anand and Hanson distinguish the use of DALYs for measuring the quantity of ill-health (the 'burden of disease') from their use for resource allocation or priority setting. They argue that the information sets required for the two exercises are quite different, and that the use of DALYs is flawed on both counts. Age-weighting and discounting of future life cannot be justified for either exercise. Weighting a year lived at age 70 at less than half of a year lived at age 25 (as the DALY formula implies) is ethically unacceptable. Similarly, discounting at a rate of 3 per cent per annum implies that one life saved today is worth more than five certain lives saved in 55 years, which the authors suggest is inequitable. Furthermore, the use of DALYs introduces a systematic bias against individuals with permanent disabilities: for a person with a preexisting disability, any illness independent of his disability will count for less than the same illness for an able-bodied person.

Given that DALYs are a measure of the burden of disease, Anand and Hanson examine the specific nature of the 'burden'. The 'burden' does not capture individuals' differential ability to cope with illness, and does not include indirect burdens on others. More seriously, the authors argue that the burden measured by DALYs is the burden of disease *and* underdevelopment, and not that of disease alone. This follows because DALYs quantify the

potential life years lost to morbidity or premature mortality in each country with respect to a standardised maximum life expectancy—that of Japan—for all countries.

Chapter 10 by Brock expands on the ethical problems that arise with cost-effectiveness analysis (CEA) in health resource allocation. CEA represents a utilitarian moral standard for resource distribution, and hence is subject to the standard problems of this approach for distributive justice or equity. Brock organises his comments on existing approaches to prioritising health-care resources in terms of the construction of the metric (QALYs and DALYs) and its use in CEA, and problems of distributive justice raised by CEA. On top of Anand and Hanson's criticisms of the construction of the DALY, he raises the problem of determining disability weights. For example, whose preferences should be used to evaluate the degree to which disability is weighted—those of the healthy or those of the disabled (who typically have very different perspectives)?

Brock raises a number of questions on distributional issues in CEA. Should priority be given to the worst-off in health-care resource prioritisation and if so for what reasons? How should we decide between small benefits to large numbers of people and large benefits to a few? How should the conflict be resolved between using resources to produce the best overall health outcomes and giving all individuals in need of treatment a fair chance to receive it?

The last two issues are taken up in Chapter 11 by Frances Kamm, which is concerned with the allocation of scarce resources related to health. She discusses microallocation problems—for example, giving a health-care resource to one person rather than another—and macroallocation problems—for example, allocating money to production of one health-care service or product rather than another. She describes the possible theoretical foundations for giving priority to some factors and not to others when allocating resources. A number of principles (the Principle of Irrelevant Good, the Principle of Irrelevant Identity, the Causative Principle, the Treatment Aim Principle) and arguments (the Aggregative Argument, the Balancing Argument, the Major Part Argument, the Moral Importance Argument, the Only Available Option Argument) are stated with the ultimate aim of arriving at a decision procedure for whom to help. Kamm also uses the principles she identifies in her chapter to reveal specific ethical problems with QALYs and DALYs, and to make suggestions for dealing with these problems in priority setting.

In Chapter 12 John Broome investigates the theoretical problems that arise in incorporating longevity in the valuation of people's health. He argues that longevity poses a special difficulty for measurement because it cannot be pinned down to a point in time. Broome discusses two types of aggregation or separability: the well-being of a single person as an aggregate of her well-being at each of the separate times in her life; and the well-being of a population as an inter-personal aggregate of each individual's well-being. With the aid of a variety of Parfitian diagrams, he shows that a 'snapshot valuation' of the distribution of well-being across people at a given point in time cannot account for longevity

differences. If we concentrate only on well-being at each point in time, we cannot detect any difference between the following possibilities, *ceteris paribus*: a single person living for a certain period, and two different people who each live for half that period where the second person is born immediately after the first one dies. The reason this problem arises is that the snapshot contains no information on the length-of-life of an individual, that is, the period for which a person's well-being continues. Broome concludes that there is no such thing as 'the health of a country at a particular time'.

## EQUITY AND CONFLICTING PERSPECTIVES ON HEALTH EVALUATION

Any evaluation of health and inequalities in health, and any policy towards health equity, must rely on value judgements and be based on particular cognitive perspectives. The origins, therefore, of these value judgements and cognitive perspectives need to be investigated. The contributions of the first four parts of the volume have tended to assume a common approach to the nature of health, which has formed the basis for its evaluation. Given this approach, the assessment of health equity is directed at the weighting of different health conditions and the identification of criteria for the just distribution of health. In contrast, the chapters in the last part of the volume address the question of how to proceed if there are conflicting accounts or narratives of health and illness. One of the main challenges encountered here is the tension between the desire to address health problems and the need to accommodate a diversity of perspectives and socio-cultural circumstances.

The three chapters in this final part all seek to strike a balance, in different ways, between universal and culturally-specific perspectives on health and health equity. Chapter 13 by Amartya Sen addresses the role of medical anthropology in health assessment, and provides the link between the first four parts of the volume and the last two chapters by Arthur Kleinman and Vincanne Adams, both medical anthropologists.

Sen contrasts two types of approaches to health assessment: the 'internal' perspective—emphasised by anthropologists—of individual experience of illness; and the 'external' perspective of public-health experts, economists, and the like, that is based on aggregate mortality and morbidity data collected through statistical surveys and censuses. Since each has its strengths as well as its shortcomings, successful policies need to take both perspectives into account. Sen discusses the experience of pain and suffering as an example of a health-related phenomenon that cannot adequately be captured by the external perspective. Relying too much on the internal perspective may, however, be misleading as well. Since perception is socially contingent, certain states of disease or disability may be perceived as normal and unavoidable, even though they are preventable. Sen illustrates a further problem with relying on the internal perspective. For example, the state of Kerala reports the highest rates of

self-perceived morbidity (internal perspective) of any state in India, while at the same time having the highest levels of life expectancy (external perspective).

Chapter 14 by Kleinman addresses a similar tension, but puts the emphasis on ethics rather than on epistemology. Kleinman contrasts the differences between the ‘translocal’ ethical discourse and local moral experiences and practices. He outlines what he calls an anthropological approach to health equity—a framework for health equity analysis that incorporates both perspectives. The chapter starts with an exploration of why both perspectives matter. On the one hand, the ethical discourse remains empty and will not fulfil its ambitions if it does not echo local moral experiences. On the other hand, local moral practices may be unethical, in which case a translocal perspective could serve as a useful corrective. The need for a translocal perspective is often endorsed by health policy-makers, but Kleinman argues that successful health policy should pay greater attention to local perspectives. With the aid of a theoretical and a practical example, he discusses how an anthropological approach would change the health equity discourse. The theoretical example relates to health rights, which are formulated on the basis of a notion of a uniform human nature. Anthropological research, however, questions this uniformity. According to Kleinman, this makes the standard discourse on health rights unviable. The practical example he discusses is that of suicide in China. Several cases bring to bear the diversity of circumstances and reasons which lead people to commit suicide. Against this backdrop Kleinman argues that without a serious engagement with local moral experience, health policy recommendations are bound to fail.

Adams’ case study of Tibet in Chapter 15 illustrates and expands on Kleinman’s framework. It examines how Tibetan life and health are affected by the secularist, modernist policies of the Chinese government. China had a leading role in the Health-for-All movement, whose goal was to secure universal access to primary health care. To achieve this goal, the Chinese government did not rely on biomedicine alone, but also made use of the practice of traditional medicine. Adams suggests that the efforts of the Chinese government should not be seen in isolation but, in the context of the broader politics of China, as a means towards the realisation of a socialist state.

She argues that a tension arises between the health policies of the Chinese government, which did allow a role for traditional medicine, and the larger agenda of modernisation and secularisation, which required the confinement of religious practices in public and social life. This tension is examined in the context of Tibet, where the repression of religious and cultural practices has curbed ethnomedicine.

Against this background, Adams discusses the link between culture and health in policies towards health equity. Through narratives of Tibetan ethnomedicine, her fieldwork documents how Chinese policies in Tibet may actually have produced stress and ill-health. Hence, she argues that the understanding of health equity should not be confined to ‘scientized’ medical theory,

but needs to accommodate an ‘equity of epistemologies’—that is of different approaches to health, to the body, and the body’s relationship to the mind and the environment.

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