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# Review Essay: Health justice and capabilities – a turning point for global health?

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## Abstract:

*This essay discusses two important recent books on health justice and makes the case for their relevance to global health and to social and political mobilization for health reform. Health and Social Justice (Ruger 2010) and Health Justice (Venkatapuram 2011) take theories of capabilities and justice onto the substantive ground of human health. They substantiate and more fully specify the capabilities paradigm, its shared basis with health rights and relevance to health reforms and the growing global health justice movement. The recent turning point for global health invites a meeting point with the capabilities paradigm. The capabilities approach offers conceptual and practical potential for 'global health', linking normative, substantive and procedural claims for health justice and health rights.*

Keywords: health justice, capabilities, global health, social justice, People's Health Assembly.

Ruger, Jennifer Prah, *Health and Social Justice*. Oxford: Oxford University Press, 2010, 276pp  
Paperback ISBN 978-019965313-3, £21.99; Hardback ISBN 978-0199559978, £48

Venkatapuram, Sridhar, *Health Justice: An Argument from the Capabilities Approach*.  
Cambridge: Polity Press 2011, 288 pp. Paperback ISBN 978-0745650357, £16.99; Hardback  
ISBN 978-0745650357, £55

## Introduction: health and the debates on justice

The past few years have seen the emergence of some important new work bringing together different strands of debate on justice in philosophy and social policy on the grounds of health. This review looks at two key works: Ruger's *Health and Social Justice* (2010) and Venkatapuram's *Health Justice* (2011). These two books take on Amartya Sen's appeal in *The Idea of Justice* (2009) to move the theory of justice in more substantive directions, to address 'manifest injustice' and social policy concerns.

Venkatapuram expresses frustration with the tendency within the philosophy of social justice to avoid directly addressing the situations of poor people and their health, even

when health and social justice are ostensibly the topics of discussion. When issues such as HIV/AIDS, or the health status of poor women in poor countries were raised, this ‘...usually resulted in sniggers or patronizing dismissals’. Pogge’s observation struck a note with Venkatapuram: ‘...speaking truth to power was not intellectually exciting’, so philosophers of social justice tended to talk to each other and stick to ‘addressing intra-academic gaps’ (cited in Venkatapuram 2011: 37). Of course, this was not the view of all philosophers of social justice and Thomas Pogge, Amartya Sen and Martha Nussbaum were some of the exceptions. These philosophers led the development of capability theory through the 1980s and 1990s, but the approach stayed largely within a contained intellectual space, far from mainstream philosophical debates on social justice. It provided the theoretical reference point for the human development paradigm, informing the United Nations Development Programme’s (UNDP) Human Development Reports. However, Venkatapuram felt that there was little actual use of the capabilities concept (2011: 141), while Ruger concurred with Pogge that the capabilities approach was still ‘drastically under-specified’, despite its potential to help the debates on health ethics and policy to break out of their current standstill (2010: 58). The past decade may have seen a turning point for global health and the recent shifts in global health invite a meeting point with capability theory. ‘Global health’ has moved from the somewhat technical recesses of disease control, to the centre of public policy, driven partly by massive funding increases and high-profile global initiatives. The changing global disease burden now highlights non-communicable diseases and there is a rejuvenated interest in the social determinants of health and health inequalities. World poverty, global inequality and the health of poor people have become more relevant and interesting to the philosophical mainstream and the works of Pogge, Sen and Nussbaum are more widely discussed and taught. Capability theory now has a chance to demonstrate its theoretical and policy relevance, but to achieve this it must move in more thickly theorized and substantive directions.

The capabilities approach is an inter-disciplinary or ‘post-disciplinary’ approach that brings together normative, empirical and policy concerns. It is a liberal approach, being ethically individualistic and pluralist, valuing freedom, diversity and choice. However, its closeness to the collective, conative concern with ‘development’ marks it out from mainstream liberal approaches. It prioritises the central human concern of wellbeing, but takes into consideration broader factors delimiting and shaping choice and personal agency. Capability theory addresses public and social policies, taking a two-handed normative and procedural approach to questions of collective action, public policy and public health. There is much that the two authors concur about, in advocating a capability approach. However, they differ in their scope and focal point – Ruger ultimately addresses domestic health reforms in the United States, applying health capability to this topical issue. Venkatapuram commends Ruger’s comprehensive approach, but complains that she does not take it far enough. He contends that health justice is a wider and deeper concern than just getting health policy right. He advances ‘the capability to be healthy’ as a route to getting broader social arrangements (‘the social policy for health’) right (2011: 28). ‘The capability to be healthy’ and the human right to health are ‘a first instalment’ of a wider project - a more complete theory of justice (2011:29; 36) that recognises health as socially produced and addresses avoidable health impairments and premature deaths as manifest injustices. Of the four broad types of influences on health (biology, behaviour, external physical environment and social conditions), Venkatapuram finds social causes ‘uniquely troubling’ and seeks to

change the status quo social arrangements, within and across countries, that thwart and neglect the capabilities of hundreds of millions of people to be healthy.

### **Critiques of mainstream approaches**

Both books begin with critiques of dominant approaches to health and health inequalities, advocating that health be treated as a moral concern. They both acknowledge that 'health' is difficult to define and that it encompasses multi-dimensional concerns, but they ultimately concur that some kind of moral consensus is necessary. Venkatapuram argues that the capability to be healthy is a moral entitlement commensurate with the human rights concept of 'human dignity' (Venkatapuram: 19; 21). Ruger speaks to the more concrete political issue of health system reform in the United States, especially topical given the current 'Obamacare' reforms, as reflections of the need for a more equitable and efficient distribution of health resources.

Both authors present health capabilities as an argument from first principles for health justice that critiques mainstream approaches in philosophy and shows affinity with a rights perspective. Ruger focuses on the politics of healthcare reforms, while Venkatapuram focuses on the meanings of 'health' itself and the argument for social epidemiology. Ruger begins with a comprehensive review and critique of existing traditional ethical approaches to health reform, encompassing utilitarian welfare economics, libertarianism, communitarianism, procedural democratic approaches, and egalitarian theories. Finding each lacking, she advances a comprehensive version of capability theory that works in the debates from health ethics, policy and law. She argues that many attempts to establish a right to health and health care fall short because they lack a principled approach to fundamental questions of prioritization and resource allocation (2010: 37). Ruger's version of capability theory brings together normative substance and procedural decision-making, through a 'joint scientific and deliberative approach' to guide allocative decisions and broader health system development and reform. Most countries, especially middle and high-income countries, are devoting rising shares of national income to health. In high-technology settings, procedures and costs are rapidly increasing. A legitimate and just form of shared health governance requires an 'evidence-based approach', relying on scientific reviews to determine medical appropriateness and best clinical practice, for example those conducted by the Federal Agency for Healthcare Research and Quality (AHRQ) in the US and National Institute for Health and Clinical Excellence (NICE) in the UK. 'Best practice' decisions are made firstly on medical grounds, before considering cost and economic efficiency. Ruger acknowledges that no decision-making system can be completely free from bias, error and uncertainty in judging 'medical necessity', but all health systems need a mechanism to determine the necessity and appropriateness of health care (2010: 183).

Venkatapuram's starting points are health equity, epidemiology and the 'social determinants' view of health. Epidemiology is an instrumental science, but one that flows from the moral value assigned to human life and longevity. The question of values arises when facts about causes, levels, consequences, distributions and possible responses are morally evaluated to determine social action (2011: 78). However, epidemiology is facing a 'paradigm crisis' (2011:75), as the disease-focused theory of health that predominated throughout the twentieth century has been criticised for narrowness and partially rejected

in favour of broader theories of health. Venkatapuram embraces a broader definition of health as the ability to achieve a set of 'vital goals' (Nordenfeldt, cited in Venkatapuram 2011: 31). However, while the 'vital goals' theory is appealing, it is too open-ended and subjective, inviting indeterminacy and relativism. Nussbaum's set of 'central human capabilities' is brought in to fill the empty set of 'vital goals', and define a life of 'minimal human dignity' (*ibid.*). However, Venkatapuram oddly refrains from specifying Nussbaum's list of ten central capabilities (see Nussbaum 2011), a rich, idiosyncratic and expansive list that is a far cry from Ruger's minimalist interpretation. Ruger's 'central health capabilities' refer to a prioritised subset of health capabilities, including '...the capacity of our organs and systems to function, [which] are necessary conditions for humanity, regardless of social context' (2010: 76).

Venkatapuram applies Sen's entitlement approach, originally used to analyse famines (Sen, 1981; Drèze and Sen 1989), to the four epidemiological causal factors: individual biology, physical exposures, social conditions and individual agency (2011: 32). The 'social determinants of health' approach was popularised by the WHO Social Determinants of Health project (CDSH 2008). This model eschews the individualistic biomedical focus on discrete, proximate exposures, ('short causal chains'), preferring to highlight longer chains of biomedical and social causal factors from the local to the global, over the entire life course (Venkatapuram 2011: 33). The 'killer facts' of social epidemiology push forward the justice issues, for example the former UN Special Rapporteur on the Right to Health, Paul Hunt, argued that maternal mortality constituted 'one of the most serious human rights issues that we face today', since a vast majority of the 500,000 deaths of mostly poor, African or Asian women annually from this cause are preventable (Hunt and de Mesquita 2007).

Ruger's interdisciplinary and substantive schema moves well beyond theoretical minimalism to elaborate a collective vision for equal access to quality healthcare, taking in problems surrounding collective norms, individual responsibility and positive health agency. Her health capability paradigm aims to optimise resources and reduce the gaps between individual's achieved and potential health, based on both health agency and health norms (2010: 141-2). This balancing act will not please libertarians as she indicates that the consensus may come down on the side of enforced social measures, where voluntary individual measures don't work. 'Health agency' is important - people must be able to monitor their own health and act to make healthcare measures effective, but institutional structures have to be in place to enable routine monitoring and action (*op. cit.*: 144). Within the normative health capability paradigm, 'health agency' requires individuals to eschew 'superficial individual preferences' (*op. cit.* 146), to self-realise and voluntarily embrace a widely shared conception of optimal and potential health over the longer run. In the real world, individuals often make choices that work against their own health (*op. cit.* 163). Health agency involves health knowledge, effective decision-making about health, self-management and the ability to control situations to pursue health (*op. cit.* 147). This includes the ability to reject false and harmful health norms that clearly do exist (*op. cit.* 149), for example amongst men in Sub-Saharan Africa, who may erroneously believe that HIV/AIDS can be cured by intercourse with a virgin. Less sensationalist but more deadly norms prevail in the West, for example smoking, drinking alcohol, poor diet and drug use. Ruger prioritises public health norms, arguing for limits on the autonomy that libertarians particularly prize.

Individuals must ultimately make choices that aid their individual and society's collective health functionings and agency. Individual, active participation is channelled towards collective norms and ends, supporting non-libertarian approaches to redistribution, oversight, regulation, tax and finance, mandates and provision (Ruger 2010: 157). While the health capability paradigm is neither strictly capitalist, nor socialist, it strongly supports public control for market failures, and the provision of public goods such as clean air and water, sanitation, medical research and knowledge, environmental health, epidemiology, and the provision of health information, communication and promotion (*op. cit.* 168). Ruger does not, however, reject 'mixed goods' which are provided by a combination of government and market, for example rehabilitative services. This is ultimately a functionalist approach to health policies which may not be up to addressing the realities of ideological political differences, history and culture. It regards functioning health systems as a necessity, and requires a social contract that commands public legitimacy and funding to deliver efficient and equitable healthcare.

### Global health and health transitions

Global health' has gradually moved from somewhat ill-defined 'fashionable concept' towards a consensus definition:

'...an area for study, research and practice that places a priority on improving health and achieving equity for all people worldwide. Global health emphasises transnational health issues, determinants and solutions; involves many disciplines within and beyond the health sciences and promotes inter-disciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care' (Koplan et al 2009: 1995).

The first great health transition began in the eighteenth century, spreading the public health benefits of clean water and sanitation (Rodin and Ferranti 2012). These changes reduced premature deaths greatly, contributing to a demographic transition in Europe. A second great transition began with the development of vaccines in the 20th century, enabling the control, or even complete eradication, of communicable diseases such as smallpox and polio. While there was a gradual shift in richer countries in the second half of the twentieth century towards problems of chronic, non-communicable diseases, the second global health transition was far from complete. Infectious disease control remains at the core of 'global health', because '...infectious diseases represent the greatest disease burden for the poor of the world, and...we in the more-developed world have the most cost-effective interventions' (Kvåle 2000: 680). The doctrines of scarcity and cost-effectiveness suggest that resources should be allocated firstly to those with the greatest needs. As the poor suffer the largest deficiencies and their greatest and most immediate threats to health come from infectious diseases, utilitarian and welfare ethics agree that infectious disease prevention and treatment must remain a global priority. Global health is also driven by the desires of medical practitioners. Global health is 'a chance for western physicians to give-and receive', delivering needed treatment to the poorer developing world, while enhancing their clinical practice, research capacity and educational experiences. In addition to its practical benefits for the poor, global health as a subject responds to a strong and growing student and teacher demand for medical education to be informed by 'international health experiences'. Such experiences offer Northern/Western physicians opportunities to re-

connect with altruism within the medical professional ethos, renewing ‘the dignity of our calling’ , in the face of perceptions that the profession is becoming dominated by utilitarian and corporate values (Shaywitz and Ausiello 2002).

Much of the ‘New Global Health Movement’ hinges on completing the work of the second transition, offering ‘a global Rx [prescription] for the world’ (Lewis 2007). There have been high-profile efforts to fund global health, to enable the ‘prescription’ to reach those populations who have not been reached. The success of global health activists in making the argument for universal access to HIV/AIDS treatment was a game-changer, providing an urgent and substantive example of the right to health in practice. Between 1990 and 2008, development funding for health quadrupled, ‘transforming global health into a crowded and multi-nodal complex’ (McCoy et al 2012: 7). Increased funding and new actors coalesced into Global Health Partnerships such as the Global Fund to fight HIV/AIDS, TB and malaria (Global Fund) and the Global Alliance for Vaccines and Immunization (GAVI). These ‘global funds’ represented new alliances between traditional public health actors such as the World Health Organization (WHO), governments, nongovernmental organizations (NGOs), the corporate business sector and private foundations (McCoy, Chand and Sridhar, 2009: 407-8). McCoy and others also note that the debt crisis and structural adjustment programmes of the 1980s and 90s had shaped a context of under-investment and weakened health systems, together with a shift in focus from a comprehensive primary health care ethos to selective primary care interventions based on a cost-effectiveness rationale (2012, 7).

The global financial crises of 2008 onwards intensified debates over the future of global health as global health initiatives were scaled back and subjected to critical scrutiny on grounds of cost, effectiveness and possible negative impact on health systems and health governance (Boseley 2011, Stover *et al* 2011, McCoy *et al* 2012). Questions were raised about the efficacy and legitimacy of the global fund-driven model, and the proper role of the WHO. One leading medical journal pointed to concerns ‘...that the influence of intergovernmental agencies is being crowded out by donor-driven funding patterns that may not be fully responding to country needs’ (Lancet 2009: 2083). This debate returned global health, after a decade or more of intense expansion, funding and activism, back to core questions about the meaning of health, the overall purpose and functioning of public health systems and to questions of legitimacy, social justice, values and policy reform, nationally and globally. Five unsolved macro-questions have been brought up again: (1) critiques of the individual disease model and the need to redefine health in ways that integrate the social and political causes of ill-health; (2) the problem of increasing health-care costs and the expansion of for-profit healthcare (3) the neglect of wider environmental damage and catastrophes as factors negatively impacting on human health, for example through immiserating displacement, injuries, spread of infectious disease and pollution harms (4) the problem of prejudice and bias implied by casting poorer people and countries as the predominant problem and threat, while ignoring (5) the structural issues of power and inequality bound up with globalizing medical bio-power and the ‘New World Order’ (Lewis 2007).

## **Health justice and social justice: a movement gathering momentum**

Both works deploy capability theory as a means to get to health reforms back to the question of justice, and start from the normative philosophical arguments for health justice. The struggle for health justice offers rich grounds to bring together and re-think central sociological concerns: structure/agency and the concern with collective action, social justice and democratization – the themes of the 2012 ISA Forum in Buenos Aires; the question of ‘public sociology’ made concrete in terms of public health and how to substantiate the concern with ‘facing an unequal world’, flagged as the central theme for the ISA’s forthcoming 2014 World Congress in Japan. A global social movement for health justice has been gathering momentum, notably since the first meeting of the People’s Health Assembly (PHA) in Bangladesh at the end of 2000. The aim was to revitalize the ‘Health for All’ demand, enunciated at the 1978 global conference and resulting ‘Alma Ata Declaration’ on primary health care. The 2000 People’s Health Assembly mobilised as a civil society counterpart to the official World Health Assembly. It convened a global encounter of grassroots health activists (‘optimists’), and produced a consensus document - the People’s Charter for Health, stating shared global goals, principles and calls for action. The second PHA in Cuenca, Ecuador in 2005 consolidated the movement for primary health across 80 countries through processes of local and national exchanges of experience, dialogue and networking. By the third Peoples Health Assembly, in Cape Town in July 2012, the movement had grown to incorporate a global health monitoring and information-sharing network, Global Health Watch; a capacity-building and training network in the form of International People’s Health Universities and a consistent presence monitoring, pressuring and advocating to the World Health Organisation (<http://www.phmovement.org/en/about>). The appointment of a relatively pro-equity and pro-primary health Director-General to the WHO, Margaret Chan, in 2006 and her re-appointment in 2012 have also enabled a more coherent return to an equitable and primary health-oriented global health agenda. The landmark 2008 World Health Report put primary health and equity firmly back into the global frame. This report highlighted five problems and three worrying trends. Firstly, the inverse care principle means that richer people who need the least healthcare get the most services. Secondly, health expenses are fast becoming a major cause of impoverishment. Thirdly, excessive specialisation and narrow disease focus has led to fragmented and fragmenting care, which fails to treat individuals holistically. Fourthly, the standard of care is sometimes unsafe, and fifthly, care is misdirected, disproportionately allocating resources to costly curative services, while neglecting the role of primary prevention and health promotion, which could prevent 70% of the disease burden. Three worrying systemic trends were the disproportionate focus on narrow, specialized curative care; the influence of global funds driving a ‘command-and-control approach to disease, focused on short-term results and fragmenting service delivery. Finally, the laissez-faire approach to governance is allowing the unregulated commercialization of health to flourish (WHO 2008).

## **Health systems reform and the third transition to universal financing**

Rodin and Ferranti suggest that the third ‘great transition’ for global health is the current vision of a global movement for health systems reform and universal financing. Addressing the World Health Assembly in May 2012, Chan remarked that the first decade of the twenty-first century had been a ‘golden age for health development’, with health becoming a top government priority. Despite funding and other setbacks since the 2008 financial crisis, she



noted that 60 countries are still seeking to reform their health systems to bring in universal health coverage as the 'right thing and the fair thing' for people's health. Declaring that 'universal health coverage is the most powerful concept that public health can offer' at present, Chan argued that it is the best way to cement the gains of the last decade. She reminded the World Health Assembly that the WHO should play more than a purely technical role in health reform - it should also act as the guardian of core social values like justice, equity, and a focus on people (Chan 2012). During Chan's first term at the WHO, the Commission on the Social Determinants of Health (CSDH) was set up, led by the epidemiologist and health inequalities specialist, Michael Marmot. Marmot admits in his foreword to *Health Justice* that CSDH was passionate about social justice, but that passion was not matched with a deep analysis of what 'social justice' actually meant. He understood that health functions as a kind of 'social accountant' – the intimate connections between health and social arrangements mean that health indicators can be used to measure social fairness and progress, or the lack of them. However, what was lacking for the CSDH was 'a better articulation of the philosophical underpinnings' that could explain why health inequalities are unjust.

Health and health reform are central to sociology because health is the very centre of the individual-society relationship. Health is central to the very existence of any individual, while collective action to decrease health deprivation and injustice is perhaps the greatest project for social cohesion and transformation. Ruger directs her opening at the question of universal coverage when she enjoins the reader to '[e]nvision a world where every man, woman and child has health insurance, providing coverage for high-quality care services' (xv). Her context is the United States and the legislative slog over healthcare reform that has led to the Patient Protection and Affordable Care Act of 2010 and its defence in June 2012. However, the 'Obamacare' proposals gave rise to a puzzling depth of opposition to much-needed reforms. Skocpol (2012) argues that the politics of US healthcare is about interests, power struggles, deliberations over solutions and mass as well as elite politics. Ruger draws on Hacker and Jacobs' and Shapiro (1997; 2000 cited in Ruger 2010: 219ff) to explain the difficulties of US health reform. They argued that universal reforms were rendered very difficult by the coexistence of partial insurance coverage and expensive public subsidies. This enabled a ruinously expensive, but technologically innovative health-care system to evolve, dominated by a powerful lobby of health-care providers and businesses. Public subsidies enabled care for the segments of the population with access to 'good' insurance coverage, but as costs rose, coverage receded and employers began to complain about insurance costs. Reforms would have to be 'comprehensive' in order to control costs and achieve coverage. The latest 2010 Affordable Care law extends coverage significantly, mandating the expansion of Medicaid to people earning up to four times the poverty line. Ruger's theoretical approach recognises that there is policy ambiguity and conflict underlying policy choice (2010: 212). She draws upon Sunstein's theory of incompletely theorized agreements (1995, cited p208) and Rawls' 'overlapping consensus' (*ibid.*) to construct a 'social agreement model of policy decision making' that combines public deliberation, leadership, communication, and popular sovereignty (*op.cit.*: 212). However, recent studies indicate that health reform failures reflect a problem of conflicting core beliefs (*op cit.* 222) and incommensurable values in a pluralist system. None of the formal political approaches explains what went wrong with the Clinton reforms of the 1990s. Then, policy makers were not guided by public opinion, but relied on 'crafted talk' which polarized

public debates. Media coverage amplified uncertainty and fears, increasing partisan conflict. Governance became ineffective as public confidence in politics generally decreased. Political scientists suggest that there is a need for a 'great public debate' about what kind of healthcare Americans want and whether they prioritize societal rights or market based commodities (Ruger 2010: 218). Ruger argues that the failure to 'effectively marshal' values to support universal coverage reforms allowed the wedge to widen dissensus and prevent agreement. Ruger suggests that the 'incompletely theorized agreement' (ITA) approach might overcome the wedge strategy. If social agreement could be reached either on high-level conceptions like health equity, or lower level principles such as willingness to help pay for other people's insurance (228), such an agreement could be used to provide a focal point around which other agreements could coalesce and enable a deeper social compromise and change. The key example is the case of civil rights campaigning where 'Americans changed and broadened their commitment to equality'. However, support for health care rights dissipated during the Clinton debacle, to the point where there is no longer support for reform based on the high-level principle. The Republican wedge appealed to core American values of individualism, distrust of government, and preference for the private sector. Ruger gives the passage of the State Children's Health Insurance Program (SCHIP) as an example of a lower order consensus achieving health reform. There was an agreement to expand coverage for children, without having to agree on the justification, or overarching political philosophy. There were a number of different reasons for enacting the legislation, such as promoting equality, prioritising children or protecting the vulnerable. States were also allowed to employ different mechanisms and models to implement the legislation (2011: 233-4). A lower-order consensus on insuring children is quite a distance away from the health capability argument for equal access to high-quality care. The norms of health capability and equal access are also a long way away from the realities of governing a mixed health system, where the government's directive and regulatory role, and role in financing, providing care, and cooperating with the private sector (171) are contentious. The Institute of Medicine suggests that some principles: universality, continuity, affordability and enhanced health and well-being can form the basis for achieving social agreement (2011: 233).

The larger vision from the capability perspective stands as a political, ethical and moral foundational approach to health policy issues. Ruger acknowledges that there are no guarantees of good health, but hopes that society can design and build effective institutions, social systems, structures, and practices that support all its members to achieve their central health capabilities. Ruger assigns the state a relatively strong role in balancing the power and roles of patients and doctors versus that of bureaucrats, insurance companies and actuaries; enabling judgements to be made about medical necessity and appropriateness, implementing rules for rationing health goods, taking responsibility for public, preventative and promotive health services and neglected diseases, and making sure that the disabled are enabled to achieve their capabilities. There is limited consensus on this role at present, and a limited appetite for public financing. The only policy measure that can be robustly pursued is the expansion of insurance. Collective arrangements and progressively funded prepayment schemes pool the risk and spread the expense. Insurance can help to maximise well-being, but it can only do this effectively if risk equalization ('community rating') is imposed to make sure insurers do not penalise poorer and sicker individuals and groups.

## Justice and health capabilities

Venkatapuram's starting point is the failure of modern theories of social justice to be relevant and responsive to the issues that face human beings and in considering different particular situations - of women, children, ethnic groups, the mentally impaired, foreigners, animals the environment and so on (2011: 12-13). Theories of justice serve as social goals and guides and they are often used to shape or justify social policies. A misconceived theory can kill and he quotes Sen's remark that '...there are many theories with blood on their hands' (*op.cit*: 14). Venkatapuram's 'capability to be healthy' consists of normative, pre-political entitlements, meaning that health justice shares similar foundations to human rights. His account of health justice begins with entitlement theory, which Sen and Drèze (1981, 1989) developed to explain the problem of famine, reframing famine as a problem of failure of human entitlements to food, not an absolute shortage of food .

Venkatapuram's enquiry began with the problem of the spread of HIV/AIDS. 'Capabilities' was a concept that helped to capture the internal and external factors that needed to be accounted for: how to engender people's control over their own bodies and change their behaviour over their lifespan, while also changing the surrounding social conditions (2011: 37). 'Health' is defined as the capability to achieve a vital or basic cluster of capabilities and functionings, and the theory of health causation and distribution must account for both individual, proximal causes and more distant social causes. The idea of entitlement can be applied to all causes of impairments and mortality and their social distribution, generalizing outward from the capability to be adequately nourished towards a broader definition of the capability to be healthy (2011: 34-5).

Both authors start by arguing that health is intrinsically valuable to individuals and that health capabilities serve as the basis for health justice. However, Ruger limits her application to decisions about health policy, specifically how public health goods and health research must be provided for and avoiding 'non-healthcare social policies' , because she thinks that we are too far from understanding the precise societal mechanisms that influence health. She concludes that it would be both unwise and unfeasible to try to improve health with 'sweeping non-healthcare policies'. Venkatapuram criticises this decision, questioning whether healthcare is the only social basis to health capability. Contra Ruger, Venkatapuram deploys Sen's argument that individuals have a 'meta-right' to social policies, notwithstanding governments' arguments that they lack the full resources or knowledge about the problems (2011: 161). However, Venkatapuram's arguments remain on rather abstract ground and he fails to elaborate any examples of broad social justice policies that could illustrate his position (Venkatapuram 2011: 153; compare Ruger 2010, 6; 98-103). Two Latin American examples come to mind - Brazil's Zero Hunger (Fome Zero) programme and Mexico's Oportunidades (formerly Progresas) programmes. Oportunidades is an anti-poverty programme which provides cash transfers to poor households which are conditional upon regular school attendance and health clinic visits. One study of the Oportunidades programme reports that school enrolment, health clinic attendance, and nutrition all improved, and the programme accounted for a 12 percent lower incidence of illness in children under five (Gertler 2000). Brazil's Fome Zero combines short term food entitlements and a monthly conditional cash grant scheme, known as Bolsa Família ('Family

Grant'), a program reaching about 12 million poor families in 2011, (while about one-quarter of Brazil's 170 million population are poor). Following the introduction of Fome Zero, doctors reported fewer children presenting at clinics with malnutrition-related health problems (Galindo, 2004). Short term measures have been complemented by longer-term, structural policies to reduce poverty and inequality including agrarian reform, social welfare reforms and job creation. De Souza (2012) reports that four major sets of government interventions: public education, a minimum wage law, Social Security pensions and Social Assistance (including Bolsa Família) have enabled Brazil to reverse patterns of very high poverty and inequality, dramatically improving these indicators since the late-2000s. Interestingly, 63 percent of the overall improvement in equality is attributed to minimum wage reforms, with 18 percent attributed to social assistance (de Souza 2012, 19).

Ruger's is an impressively programmatic work, ambitious and meticulous on both conceptual and applied fronts. She has substantively advanced the capabilities paradigm to address the complexity of health issues, where economics, philosophy and political science intersect. She bridges political-philosophical questions of procedural versus consequential reasoning, individual and collective good, questions of personal freedom versus social welfare, equality versus efficiency, and science versus economics. The book puts forward health as the great question for politics and society in a nation which has managed great technical advances, but at the cost of stark inequalities. Ruger's is the more comprehensive approach to capabilities, incorporating some fifteen principles and programmatic features. These include, *inter alia*, a social choice approach to incompletely theorized agreements (ITA), priority for essential 'central capabilities' and particular focus on equality shortfalls. This is a complicated balancing act. Choice and democratic deliberation are balanced against clinical evidence; individual health agency is balanced against with public moral norms; the benefits of markets balanced against the need to correct market failures; and a technocratic governmental approach is balanced against social movements. Social movements, which have gained so much scope in relation to health equity globally, are relegated to a largely complementary role of mobilizing coherence around norms and helping society to internalize them. The issue of public moral norms and health equity remain highly contested in the US, given the current political context dominated by a weak consensus and increasing polarization. In this context, how can procedural democracy be reconciled with the consequences of too little action? How can collective health be squared with individual subjective preferences and how can personal freedom be reconciled with social welfare? How can both equality and efficiency be achieved and can science and economics concur?

Interestingly, Venkatapuram's less specified approach is ultimately the one that best retains the real strength of the capabilities approach – as a pluralist approach to health justice that rejects standard and reductive metrics based on standardised conceptions of human beings and their needs (2011: 23). The capabilities approach stands out because it continues to hold the promise of an evaluative approach that is centred on human well-being that is linked to rights and not just economic efficiency. It poses a critique of social justice as debated by the dominant Anglo-American philosophical tradition and is the inspiration for a partial and unfinished theory of social justice and social development. At this turning point in global health, the capabilities approach serves as a counter-theory to dominant theories in several fields: the philosophy of justice, health, development, human rights, nutrition and education (Venkatapuram 2011: 25). Capability theory's nuanced critique of utilitarian

doctrines of public health and health policy mean that it continues to provide an avenue for challenging received orthodoxies of health maximisation (op cit: 26), but that work is far from complete, despite the welcome appearance of these two very substantive contributions.

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