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PERSPECTIVE

Justice in Transitioning Health Systems

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Introduction

There is a proliferation of "justice" talk in health—and perhaps rightly so. We often hear about climate, distributive, epistemic, gender, racial, reproductive, and other forms of justice. This essay adds another form of justice to the list: transitional health justice. "Transitional health justice" derives its core from "transitional justice." The latter is used by human rights scholars, political scientists, and philosophers to describe the demands of justice that appear in the context of rebuilding collapsing political systems in conflict-affected states and the processes and institutional framework required to satisfy such demands. Derivatively, transitional health justice (THJ) applies to health systems and can loosely be defined as "a set of processes and guiding principles which should be followed by states and communities affected by health emergencies in their attempts to rebuild their (failing) health systems in a just manner."[1]

Our latest brush with a global health emergency made many repeat the truism that health emergencies put an immense stress on, and sometimes lead to the failure or collapse of, health systems. Much has been written about the need to reform our health systems to render them more resilient, more prepared to deal with future large-scale health emergencies, and, overall, more just.[2] In early 2021, for example, the World Health Organization (WHO) announced its proposal to develop a convention for pandemic preparedness and response, and earlier this year a consortium released a document entitled *Principles and Guidelines on Human Rights and Public Health Emergencies* to clarify and consolidate legal standards for preventing, preparing, and responding to health emergencies.[3] Such a focus on reforming our health systems to make them more resilient, prepared for future emergencies, and more just is both helpful and needed. But often discussions about reforms center too much on the *ends* of reform: the kind of health systems that should be built and the material and ethical demands that they should be able to satisfy once reformed. And in doing so, a different kind of demand of justice is neglected—namely, demands of justice *in* or *during* health reforms. Demands of justice are context sensitive, and calls for establishing just systems are not the same

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as following the requirements of justice *during* the process of establishing those systems. Just systems are the end goal, but the pursuit of just reforms or transformation of health systems might require compromising on the demands of some other types of justice (like distributive and retributive).[4]

THJ becomes relevant because rebuilding health systems, particularly after emergencies, within a larger and ever-looming background of scarcity of resources and inequality, will require the relevant actors to make important choices and compromises. These choices will inevitably be about how to deal with past failures and the wrongs perpetrated within their respective health systems. They will also require a balance between distribution and reparation, blame and forgiveness, and truth and efficiency. Essentially, they will require attention to what we call "the circumstances of THJ." Here we intend to highlight the existence of a problem of transitional justice in the context of health. We argue that health reforms must be sensitive to the demands of THJ and that the realization of the right to health is both central to, and dependent on, the just pursuit of transformation of health and health-allied institutions.

Transitional health justice and its circumstances

The idea of THJ shares some theoretical gear with its counterpart, the transitional justice framework. Transitional justice (TJ) describes the different processes and apparatuses associated with a state's attempt to address large-scale human rights violations and abuse from past conflict and repression to serve justice and seek certainty about legitimate political authority.[5] Our account of THJ borrows some insights from Colleen Murphy, who in laying down the philosophical framework for TJ argues that demands of justice are context sensitive, in the sense that they emerge as responses to the salient problems a given society faces in a specific set of circumstances.

Given context sensitivity, the demands of TJ are conceptualized as demands of a distinct kind; they are responses to a core problem faced by transitioning societies—namely, "how to justly pursue societal transformation."[6] Traditionally, the scope of TJ is limited to an individual conflict-affected state, but given the nature of health emergencies, which are not strictly dependent on national borders, the scope of THJ is global. This means that demands of THJ will also be global in scope and character and therefore require transformation of both national and global health systems. Since the primary demand of TJ relates to the just pursuit of transformation, even if that means a momentary compromise with other ideals of justice, such as distribution, correction, and retribution, our challenge then is to identify the relevant circumstances of TJ and draw an analogy with the context of health.

Following Murphy, we list four circumstances of TJ: (1) pervasive structural inequality, (2) normalized collective and individual wrongdoing, (3) serious existential uncertainty, and (4) fundamental uncertainty about authority.[7] It does not take much to establish that analogous circumstances exist in the context of health. To take the first circumstance, it is now common knowledge that health emergencies like COVID-19, the HIV/AIDS pandemic, and even some endemics exacerbate existing structural inequalities. Structural inequalities are "reproduced social processes that reinforce one another to enable or constrain individual actions in many ways."[8] These inequalities can become widespread when they enter institutions that govern health. When this happens, and one would not be amiss to believe that this might be the case in arguably all health systems, not only are people's basic health needs put at risk, but people are also robbed of their capacity to fully trust their health systems.[9]

The second circumstance is that of normalized collective and individual wrongdoing. Collective wrongdoing during and post-emergency can range from censoring information relevant to the management of disease, to greenlighting political rallies during a viral contagion, to hoarding vaccines and then recklessly discarding the unused vaccines during a global vaccine shortage. Individual wrongdoing includes individuals aiding the spread of disease and doctors furthering inequalities through avoidable actions and behavior (for example, skipping crucial steps in the physical examination of certain groups of people or not performing them altogether, overprescribing medication, or unethically prioritizing some patients over others, among others). Health emergencies normalize such wrongdoings in the sense that they become so usual and natural that people learn to ignore and adapt to them. But this normalization can erode faith in systems that govern public health, thereby necessitating a transformation.

The third and fourth circumstances are existential uncertainty and uncertainty about authority. Existential uncertainty relates to individuals dealing with mortality and health, as in the mental health crisis that was seen post-COVID-19 pandemic.[10] More importantly, it relates to the unease surrounding the probability that health systems will ever function well. Uncertainty about authority includes individuals questioning the authority of health experts, be it epidemiologists and doctors or WHO and national governments. Such uncertainty was on display during the recent pandemic, with some even calling for anarchist solutions to the health emergency.[11]

These circumstances are markers of health systems in need of a transformation and should give governments and societies strong reasons to consider drastic transformations of both national and global health systems. It is important to note that systems in need of transformation are not the same as systems that are momentarily affected by an isolated act of war, armed conflict, or calamity. In such transitory calamities, there may be some pressing calls for the *normalization* of health—that is, for a health system to go back to what it was before the calamity, but the situation might not necessarily call for transformation. For transitioning health systems, going back to their "normal" is morally unacceptable.

So, what exactly must be transformed? In the circumstances of THJ, a moral demand for the just pursuit of transformation emerges because the mere repair or restoration of the status quo is morally unacceptable. But this demand goes beyond the transformation of material aspects associated with our health systems (e.g., health resources, health personnel, etc.). At a high level of abstraction, THJ demands that whatever contributes to the circumstances of THJ be transformed—that the circumstances of THJ come to an end. Thus, to end (or ameliorate) the circumstances of THJ, we must essentially transform how we relate to health providers, experts, authorities, institutions, and, of course, one another. Pursuing such transformation in a just manner requires a series of specific actions and an institutional framework. It will also require strengthening of the right to health. We now turn to presenting a skeletal structure of the THJ framework to then discuss the importance of the right to health for THJ.

The structure of transitional health justice

Realizing THJ will involve rebuilding social trust in health institutions. It will also require efforts toward removing, at least to some extent, the distrust regarding the authority of health experts, governments, and other health-allied institutions on questions of health; but most importantly, it will require eliminating structural health inequalities that impede institutional reform. While transformation will likely bring about some permanent institutional changes, at least some of the practices

and institutional arrangements necessary for the pursuit of just transformation will have a more seasonal character; they will exist only up until the transition has taken place, as it were. Of course, in practice, it will rarely be clear when our health systems have transitioned—and the decision to do away with the transitional framework will not be a trivial one.

THJ has a narrower scope than TJ. As opposed to the latter, the goal of THJ is not the just pursuit of societal transformation but the just pursuit of transformation of our health systems. Yet, health is embedded in social relations, and some aspects of health can be said to even be *determined by* social conditions. Thus, the choices, compromises, and reforms made in the name of transformation must be sensitive to broader social issues that affect health. One such issue, which is salient in the circumstances of THJ, is the lack of trust in our health systems and authorities. A key part of transition will therefore involve building trust in the authority of national governments and national health institutions.

One way to do so is via the mediation of independent and autonomous health agencies—those not tied in any form to existing institutions that are regarded as untrustworthy by most members of a community. Such health agencies would be constituted of vetted and reputable health scientists, health economists, community health experts, other health professionals, and community representatives. National governments and state departments would have to liaise with these agencies to implement public health management initiatives in the transitional phase—or until stronger and trustworthy health authorities are established.

Building trust will also require reasonable checks and balances to be in place during the transitional phase. In addition to independent health agencies, it would be crucial to strengthen the corpus of health law (including health emergency law) in all jurisdictions to assist the just pursuit of transformation of health systems. Here the judiciary can play an important role as an allied governing institution, particularly when it comes to challenging manifestly inadequate governmental action that leads to further erosion of trust and the furthering of inequality in a health system, as has been shown through previous positive experiences.[12]

In a world like ours, having witnessed inadequacies at every step of pandemic management, the building of trust—and the overall process of transformation—cannot simply be restricted to national authorities, law, and institutions. WHO is the main authority at the global scale, with some legal powers to respond to public health emergencies of international concern, but these powers are severely limited by state sovereignty.[13] Most of WHO's funding comes from donations by member states, and for this reason it has been accused of choosing diplomacy over transparency when dealing with some states. WHO does not have a guaranteed right of access in countries to investigate emerging outbreaks, and it cannot ensure compliance with its recommendations.[14] Part of the requirements during a transitional phase would be to strengthen WHO's ability to assist states in rebuilding their health systems. WHO is currently in negotiations to draft a convention dedicated to pandemic prevention, preparedness, and response.[15] But it remains to be seen if the convention would be able to eliminate some of the uncertainty regarding WHO's authority, strengthen the enforcement of its provisions, and include clear principles and institutional mechanisms for recovery and transformation.

Another core demand of THJ is the acknowledgment and redressal of mass-scale human rights violations that are markers of broken health systems. Traditionally, TJ frameworks rely on truth commissions to deal with past wrongs. Our THJ framework, however, breaks away from this tradition. Some violations of civil and political rights are justifiable on grounds of public emergency, but the more structurally rooted violations of economic

and social rights, like health rights, are usually not traceable to a single perpetrator. Truth commissions work when they preserve memory of past abuse and violations and promote accountability, but they can sometimes hinder health transformations because they can also increase distrust in health-related institutions, which is an essential marker of transitional health contexts and requires changing.

Bearing this in mind, we propose that transitioning health systems look at establishing "best practices commissions" (BPCs). These commissions would be tasked primarily with suggesting evidence-based practices that would best aid the transformation of a health system. They would also undertake some record-keeping and investigation of the causes and patterns of failings of the previous health system and human rights violations that took place during health emergencies. But their role would be limited to assessing the causes of failings and wrongdoings, and that would be prioritized over assigning responsibility or placing blame. In practical terms, the function of BPCs would be analogous to an ombudsperson tasked with overseeing community and national health registers, with a focus on suggesting best practices along the lines of the Good Clinical Practices.[16]

Transitional health justice and the right to health

As mentioned before, the THJ framework aims at eliminating or ameliorating the circumstances of THJ, and the circumstances of THJ include the normalization of individual and collective wrongdoing. Some of these wrongdoings will inevitably amount to serious violations of the right to health, which suggests that an integral part of transformation involves measures to reassert, uphold, and strengthen the right to health. More than that, the right to health and the transitional health framework are mutually reinforcing—while transformation is often necessary to the realization of the right, core demands of this right can guide health transformations.

There are, of course, multiple accounts of the right to health, each ascribing to it different grounds, scope, content, and correlative demands.[17] Thus, it should be expected that different accounts of the right to health will seek to guide transformation differently: the more capacious a conception of the right to health, the more robust its demands of institutional and social transformations from transitioning health systems will be. For brevity, we will not be presenting a full-fledged account of the right to health here. We will employ a legal characterization as a starting point to identify a few demands typically associated with the right to health and assess what these demands entail within a THJ framework.

One demand concerns the meaningful and effective participation of people in decision-making pertaining to their health.[18] Article 4 of the 1978 Declaration of Alma-Ata on primary health care states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care."[19] Such participation was popular during the heyday of the HIV/AIDS movement in the 1990s, but public and stakeholder involvement remains limited in health-related policy and legislative decisions today.[20] This is evident even at the global level. Despite listing community engagement and inclusiveness as its guiding principles, the Zero Draft of the Pandemic Treaty provides limited channels for community or civil society participation.[21] Our proposed transitional framework has resources to uphold this demand. Community-driven BPCs that document the concerns of all stakeholders could be given competence as one of the official channels to engage in the domestic and international negotiation of policies and agreements related to health. People suffering the after-effects of health emergencies should be able to have a say in the decisions that affect their lives. As part of

their record-keeping and investigatory function, BPCs could collect and assess recommendations from the public and be the bridge between experts, individuals, communities, and national and global health institutions. Here we can see how the THJ framework and the right to health support each other: while the right to meaningful participation in health decisions supports the establishment of BPCs, BPCs can effectuate this right.

Another demand of the right to health is that of securing people's health in a nondiscriminatory manner and providing adequate accountability mechanisms for holding authorities answerable for their acts and omissions.[22] The principles of nondiscrimination, equality of treatment, and accountability align with, and aid in fulfilling, the primary demand of the THJ framework—that of building trust between people and their health institutions. This trust has repeatedly been tested by various health emergencies.[23] But when it comes to health reforms post-emergencies, most fail to address the mass-scale human rights violations that take place during emergencies, leading to further fragility of trust. The THJ framework aims at restoring and strengthening trust through, as mentioned above, independent and autonomous health agencies, stringent checks and balances, and a strengthened corpus of health law. It requires that a robust health rights framework be both central to, and dependent upon, justly transforming health systems.

When thinking about the right to health in transitioning contexts, we should not exclusively look at how its core demands shape the THJ's framework. We should also consider how a demand to eliminate the circumstances of THJ will impact our accounts of the right to health. The right to health is traditionally seen from a vertical standpoint, centering on the duties that states owe to right bearers.[24] However, if the elimination of the circumstances of THJ is part of the scope of the right to health—as we think it should be—then any satisfactory account of this right must be more capacious and frame the right to health as imposing on individuals correlative health duties to one another, including duties to avoid normalizing individual wrongdoing during and after health emergencies. Examples of people prioritizing personal preferences over collective health interests were unfortunately myriad during the COVID-19 pandemic. The just pursuit of transformation—and the true realization of the right to health—will therefore require not only the transformation of institutions but also the transformation of our social relations more widely. Beyond rebuilding trust, the right to health should be seen as demanding that our transitional processes target the cultivation of virtues of compassion and solidarity and of social norms that prevent the dissemination of harmful health practices at both institutional and individual levels. How these can be cultivated is something that we cannot address in this contribution. We hope, however, to have conveyed the need to start a broader conversation about transitional health justice and its realization.

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