Amri *et al. BMC Medical Ethics* (2024) 25:151
https://doi.org/10.1186/s12910-024-01154-5

BMC Medical Ethics

RESEARCH Open Access

Health equity and distributive justice: views of high-level African policymakers

Michelle Amri[1*], Borgar Jølstad[2] and Jesse B. Bump[3,4]

Abstract

Health equity matters, but there is no universally accepted definition of this or associated terms, such as inequities, inequalities, and disparities. Given the flexibility of these terms, investigating how policymakers understand them is important to observe priorities and perhaps course correct. Accordingly, this study analyzed the perceptions high-level policymakers within the WHO African Region. An online survey was distributed to attendees of the WHO's Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region by email. After responses were collected, both inductive and deductive coding were applied. Inductive coding was undertaken to glean central concepts from free-form responses on understandings of health equity and deductive coding was used to assess alignment with four theories of distributive justice using a coding framework. In analyzing central concepts, three became apparent: access to health services and/or health care, financial protection, and recognizing subgroups. And when we investigated alignment with theory, most respondents' understandings of health equity aligned with Rawls' 'Theory of Justice' (95%). Of these responses, 70% were exclusively aligned with Rawls' 'Theory of Justice' and 30% aligned also with another theory (this 30% was split 55% utilitarianism and 45% Sen's Capabilities Approach). Respondent understandings of health equity showed limited alignment with other theories of distributive justice, which were: utilitarianism ($n=7/39$; 17.95%), Sen's Capabilities Approach ($n=5/39$; 12.82%), and libertarianism ($n=2/39$; 5.13%). Our study demonstrates that alignment with certain theories is tied to specific themes (i.e., theoretical underpinnings may guide policymakers to favour certain policy approaches). For instance, a utilitarian-minded policymaker may be focused on a widespread vaccination campaign, whereas a Rawlsian-aligned policymaker may focus on a targeted approach to reach communities that have lower vaccination rates, and a Senian-aligned policymaker may focus on health literacy programs targeted at addressing vaccine-hesitant individuals within communities with lower vaccination rates. These findings can guide high-level policymakers and international organizations to optimize decision-making by clarifying ethical alternatives.

Keywords Theories of distributive justice, Justice, Health equity, Health inequity, Health inequality, Health policy, Health governance, Global health, International health, Welfare economics

*Correspondence:
Michelle Amri
michelleamri@gmail.com
[1]The W. Maurice Young Centre for Applied Ethics, School of Population and Public Health, University of British Columbia, 2206 East Mall, Vancouver, BC V6T 1Z3, Canada
[2]Akershus University Hospital, the Health Services Research Unit – Helsetjenesteforskning (HØKH), Sykehusveien 25, Oslo 1478, Norway
[3]Takemi Program in International Health, Harvard T.H. Chan School of Public Health, Harvard University, 665 Huntington Avenue, Bldg. 1, Boston, MA 02115-6021, USA
[4]Bergen Centre for Ethics and Priority Setting, Department of Global Health and Primary Care, University of Bergen, Post Box 7804, Bergen N-5020, Norway

Introduction

Health equity matters to many, but how it is understood can vary widely, as evidenced through investigations of the World Health Organization (WHO) [1–4]. For instance, health equity can be sought by targeting a population sub-group, reducing inequities across all facets of the population, universal provision of a service or good, upholding full health potential for all, and others [4, 5]. Recent investigations into the WHO's engagement with health equity, begin to illustrate how institutions may approach this central concept in global health [1, 3, 6]. For instance, WHO specifies three explicit approaches to health equity, but several additional implicit approaches were identified by critical discourse analysis [4]. Another study investigated how equity was reflected in the WHO's Urban Health Equity Assessment and Response Tool (Urban HEART) [2]. Key informants involved in Urban HEART broadly understood key aspects of health inequity but felt the concept of health equity was vague, raising question about how it was incorporated [2]. Although these analyses point to how WHO texts and key informants have approached health equity, we are not familiar with any such analysis of government actors, which would be equally important, if not more so. Given the role policymakers play in determining policy priorities and designing public policies, understanding their approaches to health equity is critical, given that decisions around trade-offs need to be made (e.g., who will be targeted to receive health services and who will not).

This study sought to understand how directors of policy and planning, managers, and other high-level policymakers at the central/national government level[1] within the WHO African Region understand health equity. Our focus on policy and planning sought to capture those who are working in strategic health policy broadly, as opposed to those working in a specific area (e.g., primary health care, curative services, nutrition). More specifically, this study assessed key themes in how these individuals understand health equity and how their views aligned with theories of distributive justice. Therefore, our research question is: how do high-level policymakers understand health equity and how do their views align with theories of distributive justice? Distributive justice entails "how a society or group should allocate its scarce resources or product among individuals with competing needs or claims" [7]. Evidently, distributive justice is not a neutral term [8]. Distributive justice deeply relates to health equity given that health equity seeks to remedy health inequities (which can be understood as differences which are unnecessary, avoidable, unfair, and unjust [9]). As such, we felt it was important to assess alignment of policymakers' views with differing theories of distributive justice to determine what policymakers deem important to strive for. In other words, what trade-offs are they willing to make? Our inquiry focused on four theories of distributive justice: (i) libertarianism, (ii) utilitarianism, (iii) Rawls' 'Theory of Justice', and (iv) Sen's Capabilities Approach—all of which are identified as four modern theories of distributive justice that have had the most impact over several decades [10].

First—libertarianism—positions the rights of individuals over that of society [10]. Libertarianism and neoliberals believe that the market will afford freedom and the ability to exercise choice [10]. Thus, it is understood that there is no need for government intervention [10]. As such, the only equality that is the matter for government is equality under the law.

Second—utilitarianism—proposes that the correct course of action is the one that maximizes utility, typically understood as preference satisfaction [11] or hedonic states [12]. Thus, the focus is on improving the welfare of a community, in the form of maximizing either the total utility of a community (total utilitarianism) or the individual average utility (average utilitarianism) [13]. Utilitarianism is based in the principle that everyone's interests matter equally. When everyone's interests matter equally, it is unjust to prioritize the interest of some (such as the worse off) over others unless they can be helped to a larger extent. Utilitarians seek the greater good and are focused on securing a better outcome no matter who the beneficiaries are. Specific attention is not paid to what the outcome may look like for specific groups.

Third—Rawls' 'Theory of Justice'—is an egalitarian theory positing that justice should not be focused on welfare, but rather the provision of primary goods (i.e., rights or resources), and that the distribution of goods is just when the worst off are as well off as possible [7, 10, 14]. Rawls' theory of justice is a form of egalitarianism: theories that attribute value to the equal distribution of welfare or goods. Rawls' theory is a radical version of egalitarianism because it embraces the difference principle: social and material resources should be distributed to the greatest advantage of the least advantaged [14]. That is, inequity is only just when no other distribution of goods would lead to a better outcome for the most disadvantaged. Other versions of egalitarianism attribute some weight to equality, while also valuing aggregate welfare (see for example [15] for a theory of lifetime Quality-Adjusted Life Year (QALY) prioritarianism, or [16] for an overview of varieties of egalitarian theory). What makes Rawls' theory particularly relevant in this study is its focus on the worst off.

And finally—Sen's Capabilities Approach—which is another egalitarian theory, does not focus on welfare or

[1] We initially sought respondents working at the central/national government level. However, some respondents reported not working at this level, but we elected to include these respondents if they played a significant role in policy and planning.

primary goods, but instead, capabilities, which are capabilities for functioning [7]. The focus on capabilities is supported by two propositions that seem morally relevant. First is the fact that the provision of primary goods to individuals does not result in the same output for all individuals. People with disabilities for example often require more resources to achieve the same level of welfare as people without disabilities. Secondly, that what matters morally is not principally how well-off people are in terms of well-being, but rather whether they have the *opportunity* for well-being. Thus, maximization of individual capabilities is sought or the equalization of capabilities among individuals, the latter of which was expressed by Sen at a later date [7]. Alternatively, one can argue that the most important duty is to raise people to a certain threshold of capabilities [17]. So, the Capabilities Approach is primarily a theory of the relevant good for distributive theory, while different theoreticians have proposed distributive principles such as maximization, equality, or sufficiency. In the context of this paper, we discuss the Capabilities Approach as a way of thinking about what kind of equality matters. Capabilities can require primary goods, and capabilities in turn enable functioning and well-being [7]. Thus, Sen's Capabilities Approach can be understood to be neither resource nor welfare focused, but fall between these two [7], in the sense of being less subjective than utilitarianism, but more focused on individual characteristics than Rawls' theory.

We elected to not draw on the theory of ubuntu despite its relevancy because varying ideas around what this entails makes it difficult to categorize data accordingly. We understand ubuntu to mean "a collection of values and practices that black people of Africa or of African origin view as making people authentic human beings" [18]. Ubuntu values and practices denote that an "authentic individual human being is part of a larger and more significant relational, communal, societal, environmental and spiritual world" [18]. Or "personhood is constituted through other persons" [19]. In other words, ubuntu places the common good in centrality, whereby "individual […] interests do not conflict with the common good" [19], and solidarity and relational justice are key [20]. At the same time, ubuntu arguably respects individual uniqueness, as ubuntu does not equate to consensus, nor does it conflate the "I" and "one" [19]. We also recognize the view that the relationship between individuals and society is not clearly definable, nor is it simplistic, leaving the precise definition of ubuntu unclear [21]. Ultimately, we felt we could not appropriately categorize responses with this theory given the inherent "inadequacy" in defining the term, or the "infinite contained in the finite", which should seemingly reflect both the work of (i.e., everyday existence) and discourse on ubuntu (i.e., reflections to understand actions) [22].

Our study demonstrates that theoretical orientations are tied to themes and theoretical underpinnings that may guide policymakers to favour certain policy approaches. We anticipate that results of this research can guide the development of public policy focused on health equity. As such, the goal is to draw on these findings to inform the work of the WHO, at the country office, regional office, and headquarter levels, as these considerations have implications across these levels and beyond and can guide WHO technical support within countries. Therefore, through understanding perceptions of high-level policymakers, not only will these results contribute to enhanced knowledge around health equity considerations in public policy but can also lead directly to action.

Methods

Study design

This study employed an exploratory cross-sectional survey to glean insights about how respondents understand health equity. The survey is available in the Supplementary File.

Focus on the African Region per the WHO

We felt it was important to focus on the African context given that these high-level policymakers are well-versed in public health initiatives and balancing various health needs (e.g., addressing communicable and noncommunicable diseases). We elected to focus in on the African Region per the WHO's definition for two reasons. First, this study was endorsed by the WHO Regional Office for Africa. As such, we wanted the findings to be relevant for the region to subsequently utilize study findings as they see fit. And second, given the focus on high-level policymakers and the WHO's strong working relationship with ministries of health, this allowed for a natural way to reach such high-level policymakers focused on policy and planning. Pragmatically, potential respondents were invited to and/or attended the Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region. It would have been difficult to appropriately locate additional policymakers (e.g., in North African countries) without working relationships.

Institutional research ethics board exemption

Harvard University's institutional research ethics board provided ethics exemption for this study (protocol number: IRB21-1176) and informed consent was received from all respondents. Institutional research ethics board approval was not sought from the WHO Regional Office for Africa as the researchers were not conducting this work on behalf of the WHO—however, study

endorsement was received. Nor was approval sought from institutions within the region, given the multi-country approach and because none of the researchers are based within the region.

Consultations and survey development

Draft survey questions were developed and discussed during individual consultations with six directors of policy and planning or those at similar levels within governments across Africa (i.e., in some cases, these individuals had different titles but operated at an equivalent director level). These consultations both discussed the overarching aims of the study and assessed the value-add of this work and solicited feedback on draft survey questions which allowed for enhanced refinement and granularity. All directors who were consulted felt the study provided value and was worth pursuing. MA discussed each draft survey question with directors and most suggested revisions were made (e.g., asking respondents to specify the focus of their work). In some cases, suggestions were not applied (e.g., providing an honorarium).

Survey distribution

Following these consultations, the survey was finalized, developed on Qualtrics, and distributed by email using a message shared with the institutional research ethics board. The email contained English, French, and Portuguese text alongside the link to the survey, which was also available in three languages. Both the email message and survey were translated from English using DeepL [23]. The distribution list was developed using the email addresses of those invited to the WHO's Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region (n=481) [24, 25]. Emails with the following institutional domains were eliminated: who.int; unicef.org; giz.de; unfpa.org; pasteur.sn; kemri-wellcome.org; gavi.org; gatesfoundation.org; dfid.gov.uk; and worldbank.org. This resulted in n=199/481 email addresses that did not bounce back once the survey was distributed. Similarly, email addresses sourced from an online list of ministry of health policy focal points that did not bounce back and were not duplicates were also contacted (n=55).

The compilation of these two lists resulted in n=254 potential respondents. However, this list also includes various individuals (e.g., seven email addresses with one university domain, translators, observers) that were not eliminated as it is difficult to discern who is relevant to the study (e.g., an alumnus who uses their university email address but now works as a civil servant).

Email blast strategy and response rates

A subset of 50 individuals from the full list was contacted to pilot the survey to see if any readjustments were to be made. On an approximately weekly schedule, emails were sent four times to the same 50 potential respondents from this list. Following this piloting, no adjustments were made to the survey, and the full list was subsequently emailed over the next several weeks. An email from a WHO official encouraging participation in the study was sent and no emails to encourage participation were sent following this. The response rate was 16.5%, as data from n=42/254 respondents was compiled, with n=41 completing the survey in full. However, this is not an accurate representation of the response rate, as many participants at the meeting would not be relevant individuals partaking in the study, such as report writers, translators, and other observers.

Survey content and data analysis

The survey contained a preamble that explained the focus of the survey, the voluntary nature, the possible risks, time commitment, ability to decline, invited respondents to complete the survey, and thanked respondents for their time and participation. In addition to collecting demographic information, respondents were asked about how they understand health equity and were asked to describe this in their own words.

All responses in French and Portuguese were translated to English using DeepL [23]. Inductive coding was undertaken to glean central concepts by undercovering themes from free-form responses on understandings of health equity and deductive coding was used to assess alignment with theories of distributive justice. Thus, an a priori coding framework was applied to assess alignment with the above theories of distributive justice, which are outlined in Table 1. Coding was conducted in NVivo 12.

Table 1 Coding framework to assess alignment with theories of distributive justice

Theory of distributive justice	Libertarianism	Utilitarianism	Rawls' 'Theory of Justice'	Sen's Capabilities Approach
Codes	• rights • market • free will • choice • no government intervention	• greater good • individuals are equal and attention is not paid to worse-off sub-populations	• provision of goods to worse-off sub-populations (e.g., service delivery based on need) • equal opportunity	• differing individual capabilities • achieving one's full health potential

Results

Demographic information

Data was collected from respondents in 18 countries of the 47 countries within the African Region, as outlined by the WHO. The number of respondents from their respective countries is noted in Table 2 and illustrated in Fig. 1. Respondents in higher-ranking positions were contacted through the sampling strategy, including directors of policy and planning, managers, and policymakers at a similar level. Many respondents work in health policy development (n=10/41) and health planning (n=10/42), followed by health financing (n=8/41). However, additional respondents who selected the "other" category specified that they work in more than one of these areas. Of note, this raises the number of respondents working in health policy development (n=12/41), health planning (n=11/42), and health financing (n=10/41). Further, most respondents work at the central or national government level (n=35/42), which was the target group for this survey. However, some respondents shared the study with their regional counterparts who completed the survey (full respondent demographics are available in Table 1). Given the identification of these regional counterparts as being relevant for inclusion in the study by their colleagues, we have elected to include their responses.

Table 2 Respondents' demographic information

Characteristic	Number of respondents	Percentage of responses
Respective country	n=41	
Burundi	4	9.76%
Cabo Verde	1	2.44%
Central African Republic	2	4.88%
Comoros	2	4.88%
Congo	4	9.76%
Ethiopia	4	9.76%
Ghana	1	2.44%
Guinea	1	2.44%
Lesotho	3	7.32%
Liberia	1	2.44%
Madagascar	1	2.44%
Malawi	4	9.76%
Mali	1	2.44%
Rwanda	1	2.44%
Seychelles	1	2.44%
Sierra Leone	2	4.88%
South Africa	1	2.44%
United Republic of Tanzania	6	14.63%
Prefer not to answer	1	2.44%
Focus of respondents' work	n=41*	
Health policy development	12	29.27%
Health planning	11	26.19%
Health financing	10	24.39%
Health research	5	12.20%
Minister's or Secretary General's office	2	4.88%
Health partnerships	1	2.44%
Other	5	12.20%
Those who work at the central/national government level	n=42	
Yes	35	83.33%
No	7	16.67%

* Please note that some respondents specified multiple roles in the "other" category. These multiple roles are reflected in true categories, while ensuring the "other" category accurately reflects responses that did not fit into the outlined categories.

Central concepts in understandings of health equity

Three key themes became readily apparent in respondent understandings of health equity. These themes are: (i) access to healthcare and/or health, (ii) financial protection, and (iii) recognizing subgroups.

First, there was an overwhelming emphasis placed on access to health *services* and/or health *care*. This was discussed in terms of access to resources and services (e.g., "Equity as I understand it refers to having equal opportunity to access resources and services one needs") and quality health care (e.g., "All people have access to quality health care when they need it without financial barriers")—and variations of this language. However, select respondents also discussed access more broadly in terms of access to *health* more generally (e.g., "Equity is about ensuring that access to health is commensurate with health need so that people who need to access health are able to do so at the point of need and that in accordance to their level of need", "equal access to health…"). Thus, it is worth noting that this focus on access when discussing health equity was predominantly around access to health *services* and *care*, as opposed to preventative efforts, healthy public policy, or just simply health and well-being—despite some broader mentions of access to *health*.

Second, respondents identified financial protection when discussing health equity—although without explicit mention to this term. Financial protection was discussed both in terms of having no financial barriers and at an affordable cost. Having no financial barriers was discussed by responses such as "All people have access to quality health care when they need it without financial barriers", "equal access to health despite one's ability to afford in cash or none cash, physical, geographical, gender, age, political, etc", and "…This includes equal access, irrespective of ability to pay for example"). And at an affordable cost was mentioned through statements such as "That each individual has the care they need at a cost they can afford", "…and that this should not lead to financial hardship", and "Provision of quality health care services to all people regardless of […] who they are and

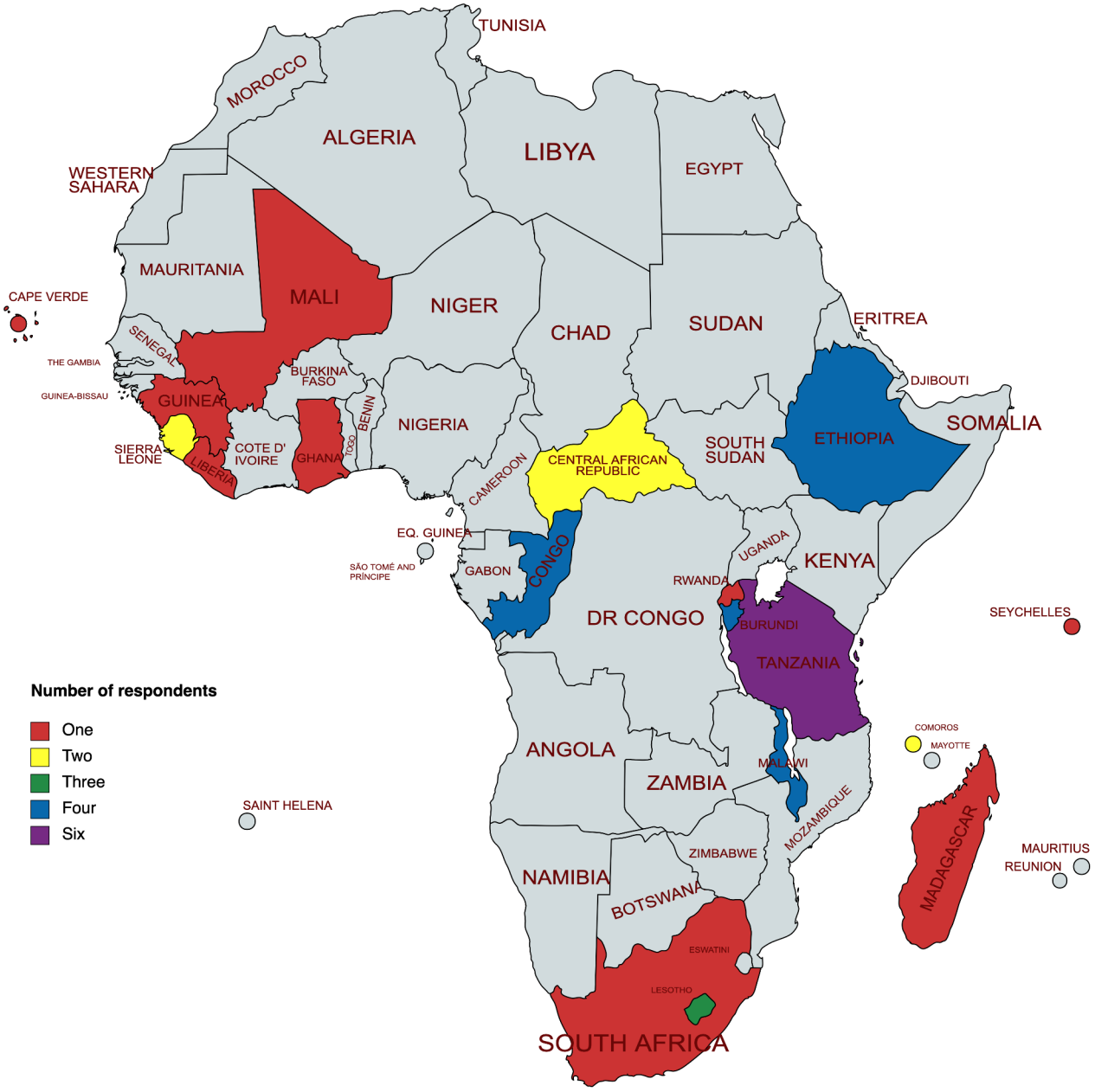

Fig. 1 Illustration of representation from across the region

without causing financial hardship on them or their families". We feel it is noteworthy to observe that almost all respondents working in health financing discussed health equity in this way, but many working outside of health financing also discussed financial protection.

And lastly, many respondents mentioned that health equity entails that health services are provided to all groups or ensuring that services are provided with particular attention paid to vulnerable or disadvantaged groups, with some explicitly listing subgroups (e.g., women and children). Characteristics explicitly mentioned by respondents included individuals with differing: income/economic status, social status, geographies and territories, physical conditions, gender, age, political affiliations, ethnicities, race, sexual orientation, religious affiliations, language, urban/rural, and disabilities.

Table 3 Alignment of respondent understandings of health equity with theories of distributive justice

Response	Libertarianism	Utilitarianism	Rawls''Theory of Justice'	Sen's Capabilities Approach
1		X	X	
2		X	X	
3		X	X	
4			X	
5			X	
6			X	X
7			X	X
8			X	
9			X	
10			X	
11			X	X
12				
13			X	
14			X	
15			X	
16			X	
17			X	
18			X	
19			X	
20			X	
21			X	
22	X			
23			X	
24			X	
25			X	
26			X	X
27			X	
28			X	
29			X	
30			X	
31			X	
32				
33			X	
34			X	
35			X	X
36		X	X	
37			X	
38			X	
39	X	X		
40		X	X	
41		X	X	

Understandings of health equity and alignment with theories of distributive justice

In addition to the above thematic analysis of the various areas of emphasis afforded in understandings of health equity, respondent understandings of health equity were assessed for alignment with four different theories of distributive justice: (i) libertarianism, (ii) utilitarianism, (iii) Rawls' 'Theory of Justice', and (iv) Sen's Capabilities Approach. There were two responses that were not clear and/or substantive enough to delineate alignment with theories, thus dropping the total from $n=41$ to $n=39$, and some understandings of health equity aligned with two theories ($n=12/39$; 30.77%). How respondents' understandings of health equity aligned with the theories of distributive justice under investigation are outlined in Table 3 and discussed in greater detail below.

Overall, most respondents' understanding of health equity aligned with Rawls' 'Theory of Justice' ($n=37/39$; 94.87%). Of these responses, 70.27% ($n=26/37$) were exclusively aligned with Rawls' 'Theory of Justice'. In other words, 29.73% ($n=11/37$) also demonstrated alignment with another theory of distributive justice. The

two remaining responses that did not algin with Rawls' 'Theory of Justice' were solely aligned with libertarianism (n=1/39; 2.56%) and demonstrated elements of both libertarianism and utilitarianism (n=2/39; 5.13%). For these two individuals, we do not observe any specific characteristics that would lend themselves to these responses (e.g., respondent country). Respondent understandings of health equity much less aligned with the other theories of distributive justice under investigation, which were: utilitarianism (n=7/39; 17.95%), Sen's Capabilities Approach (n=5/39; 12.82%), and libertarianism (n=2/39; 5.13%).

There were several responses that demonstrated alignment with two theories (n=12/39; 30.77%). These understandings reflect elements of: utilitarianism and Rawls' 'Theory of Justice' (n=5/39; 12.82%), Rawls' 'Theory of Justice' and Sen's Capabilities Approach (n=5/39; 12.82%), and libertarianism and utilitarianism (n=2/39; 5.13%).

Libertarianism

There was only one response that solely aligned with libertarianism (n=1/39; 2.56%) and another that aligned with both libertarianism and utilitarianism (n=1/39; 2.56%). The one respondent whose understanding was solely aligned with libertarianism noted that "to act in the best way in the respect of the persons, which requires actions framed by the law." This view aligns with libertarian notions of ensuring individual freedoms and rights. The second respondent whose views also aligned with utilitarianism noted both every citizen's rights (i.e., libertarianism) and the duty of the government (i.e., utilitarianism).

Utilitarianism

There were no responses that solely aligned with utilitarianism, but 17.95% of responses demonstrated alignment with utilitarianism and another theory (n=7/39). Of which, six also aligned with Rawls' 'Theory of Justice' (n=6/7; 85.71%) and one aligned with libertarianism (n=1/7; 14.29%). In responses that also aligned with Rawls' 'Theory of Justice', there was an element of need that appeared without being explicit about providing goods to worse-off sub-populations. These understandings of health equity mentioned ensuring access or providing services for all but also balancing this view with mentions of individuals accessing these services solely based on need (e.g., "people who need to access health are able to do so at the point of need and that in accordance to their level of need", "users of health care must consume health care based on no other factor than their need for it"). The utilitarian aspect of these quotes are evident in their focus on the extent to which people can benefit from intervention (their need) and the lack of attention to other factors.

Rawls' 'Theory of Justice'

Most respondents' understandings of health equity aligned with Rawls' 'Theory of Justice' (n=37/39; 94.87%), of which, 70.27% (n=26/37) were exclusively aligned with Rawls' 'Theory of Justice'. Respondents commonly mentioned the need to provide goods to worse-off sub-populations (e.g., "measures are put in place in ways that most likely will ensure equal health outcomes also for vulnerable groups among the larger population", "addressing the health concerns of disadvantaged groups") and indicated the need to eliminate financial barriers (e.g., "access to health despite one's ability to afford in cash or none cash", "irrespective of ability to pay for example", "should not lead to financial hardship"). These responses reflect a view that we should pay specific attention to the worse off (the "disadvantaged" and "vulnerable groups") to make sure that they have equal access to healthcare.

Sen's Capabilities Approach

Although there were no responses that solely aligned with Sen's Capabilities Approach, five responses demonstrated alignment with Sen's Capabilities Approach and Rawls' 'Theory of Justice' (n=5/39; 12.82%). These responses noted the need to consider the unique needs and circumstances of each individual (e.g., "Take into account the needs and specificities of … individuals", "It is access to quality services adapted to the socio-cultural and economic conditions and needs of the populations") and striving for individuals to reach their full health potential (e.g., "Ensuring that everyone has access to attain their full health potential", "Health equity is achieved when people have an equitable opportunity to reach their full health potential. Achieving health equity requires reducing unnecessary and avoidable differences that are inequitable and unfair"). Although many respondents commented on the need to address worse-off *groups*—per Rawls' 'Theory of Justice'—it is the recognition of unique *individual* needs—or functionings and capabilities, per the Capabilities Approach—that differentiated responses to be categorized as aligning with the Capabilities Approach.

Discussion

The findings of this study not only show that high-level policymakers have different understandings of what health equity should be focused on, but also approach this work with different theoretical underpinnings. It was not unexpected that respondents focused on these three areas—access to health services and/or health care, financial protection, and recognizing subgroups—given that much of the global health rhetoric is focused on universal health coverage which has a large focus on access and financial protection. Similarly, we are not surprised that respondents' views aligned with Rawls' 'Theory of Justice',

given that Rawls' 'Theory of Justice' is arguably the most prominent contribution to the social justice literature [26] and that focusing on the worst-off often seems to be synonymous with health equity in public and global health. However, it is striking to see that very few respondents' views aligned with Sen's Capabilities Approach given that it is not mutually exclusive from Rawls' 'Theory of Justice'. Further, we found it notable that a few respondents' views did not align with Rawls' 'Theory of Justice'—or Sen's Capabilities Approach, although those who aligned with this approach also aligned with Rawls—as this means these individuals do not recognize the need to provide primary goods or believe that the worst off should be as well off as possible. In many ways, we feel this is antithesis to much of global and public health.

When cross-comparing thematic and theoretical findings, we note that different theoretical orientations align with emphasizing certain themes. Those who held libertarianism views discussed ensuring appropriate laws and awareness of rights, those who held utilitarian views were focused on ensuring services for all, those who held a Rawlsian perspective focused on worse-off sub-populations and eliminating financial barriers, and those who held a Senian perspective were focused on considering the unique needs of individuals to guide them to reach their full health potential.

Theoretical underpinnings may guide high-level policymakers to emphasize and favour certain policy approaches. For instance, a utilitarian policymaker may be focused on a widespread vaccination campaign, whereas a Rawlsian-aligned policymaker may focus on a targeted approach to reach communities that have lower vaccination rates, and a Senian-aligned policymaker may focus on health literacy programs targeted at addressing vaccine-hesitant individuals within communities with lower vaccination rates.

Priority setting as an area of inquiry brings people together from various backgrounds, with differing experiences and normative views. Discussions in this space are bound to be complex and sometimes conflicted. When terms such as health equity are used in differing ways by differing people, we risk perpetuating misunderstanding or masking differences. For example, because a common definition of health inequities contains the word "unnecessary" (i.e., differences that are unnecessary [9]), this term has been intentionally debated to prohibit political action [2]. Or in considering how to act to combat health inequities or promote health equity, differing approaches can be laid out [5]. Our results show that health equity is used differently by different actors, which can help clarify this term. We believe this is a helpful contribution to the literature as we are unaware of any empirical applied ethics work assessing policymaker views of health equity and alignment with theories of distributive justice.

There are wide-ranging implications for this work. For instance, there is a focus on health equity in some multisectoral policy approaches that bring together stakeholders from different sectors (e.g., Health in All Policies approach, Healthy Cities) [27–30]. Given that different understandings and theoretical orientations of health equity can lead to differing actions, there is a need to consider relevant stakeholders' conceptualizations of health equity, their perspectives on justice, how these differing views can lead to preferring different programmatic and policy actions, and ultimately, how to balance and align views to achieve common goals. We recommend policymakers carefully reflect on how their own theoretical understandings and perceptions of health equity may lead to blind spots. And further, that policymakers deliberate and clearly articulate how they seek to combat health inequity and who exactly they seek to address. Through meaningful discussions, we believe consensus can be reached on how to design public policy that improves the determined collective notion of health equity.

Given that this was a WHO-endorsed study, we also feel there is room for the WHO to reflect on the potential repercussions of these findings. It may be helpful for the WHO to consider existing explorations of the WHO's approach to health in the literature whereby inconsistencies emerge (see [1, 4]) and consolidating these with what high-level policymakers in our study shared. Health equity is a conceptually difficult term for many to grasp, so we suggest consideration be afforded to how such challenges, misconceptions, and so forth can be cleared (e.g., through webinars).

Limitations

Data collection

It seems that there is a relatively small response rate at 16.5%. However, this fits within the range found in research that looked into web-only surveys and found response rates range between 8 and 44% [31]. Additionally, this response rate is highly nuanced, given that the full participant list from the WHO's Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region and a list of relevant focal points was secured from online (unable to locate this online list as of November 2024). With the email addresses of participants at this meeting, many individuals who are not the focus of this study are included on this list (e.g., translators). Therefore, it is not possible to determine the correct denominator to be able to accurately calculate the response rate. However, the response rate does not devalue the study, but can simply inform future studies using survey methods.

Although the survey is not designed to be generalizable or representative, there were no responses collected

from select countries, and similarly, there was a higher response rate from some countries (e.g., the United Republic of Tanzania with $n=6/41$). There is a need for further studies to collect missing perspectives. Additionally, by collecting missing perspectives, future analyses can assess any potential associations between countries of respondents, level at which they work, and foci of work (beyond those working in health financing) with their views of health equity. For example, one may be able to determine if financial protection is more relevant to respondents from countries with high out-of-pocket expenditures.

Study design and data analysis

This study was conducted in English, French, and Portuguese. Responses in French and Portuguese were translated using DeepL [23] computer software which may lead to inaccurate translations. For instance, if there are specific nuances inherent in the use of a specific word or expression, this may not be conveyed in the computer-translated version.

The study employed a survey, which does not necessarily lead to rich data by design. As an illustrative example, a respondent noted that "It's to way to solve problem in considering everyone in all determinants of life." It is not possible to assess alignment between this respondents' understanding and theories of distributive justice (e.g., does addressing different determinants of health constitute resource provision in line with Rawls's views? Or does considering everyone entail an understanding of unique capabilities in line with Sen's views?). If this was an interview, the interviewer could probe the respondent to elaborate on the intended meaning and glean a more fulsome understanding of their view. Thus, we suggest future researchers undertake interviews to glean a more fulsome understanding.

This study treated alignment with theories of distributive justice as not being mutually exclusive. In other words, codes were applied to assess any alignment with theories of interest. However, these theories have fundamental differences that are more apparent in their respective nuance. Such nuance is difficult to discern through the study design. For example, the six respondents whose views aligned with both utilitarianism and Rawls' 'Theory of Justice' largely mentioned ensuring the provision of services for all, but also ensuring no financial barriers or equal opportunity. These respondents' views were deemed to have such alignment through using the a priori codes. On the other hand, not all these views are necessarily in disagreement. Participants may hold complex views that do not completely map onto the theoretical alternatives. Thus, we also recommend future research undertakes key informant interviews to delve into these issues in more depth.

We did not categorize responses using ubuntu or other African concepts or approaches (e.g., Made in Africa Evaluation [32]) given that we could not infer alignment with specific actions (e.g., laws) or distributions (e.g., addressing the worst-off). As such, we feel there is much left to unpack and explore. For instance, additional analyses can draw on a Made in Africa Evaluation that is informed by African philosophical assumptions [33] to point to novel insights around how health equity is being sought within countries. Such insights can be helpful for broadening mainstream approaches to health equity employed by the WHO and other global health institutions and can help resolve differences in understanding and contribute to guiding robust collective action.

And lastly, this article is written by authors not based in the African continent. Our intention of conducting this analysis is not to respond to the "foreign gaze" [34], but instead, to shed light on challenging ethical questions around health equity in policymaking globally with the ultimate aim of contributing to enhancing public policymaking. The lead author of this work has worked in this space and is planning to conduct related analyses in her home country of Canada. The lead author was a consultant for the WHO Regional Office for Africa and in attendance at the regional meeting, which facilitated access to WHO-endorsement and access to key informants. We have sought this journal focused on ethics to reach those interested in questions around how health equity is understood and how action should be sought and distributed. We will share the published findings of this work with those who participated in this study, as we feel having reciprocity in conducting this research is important [35]. Although we are unable to translate the findings to African languages, we also feel it is appropriate to share the message in the languages the study was conducted in (English, French, and Portuguese) to not assume any respondents' working languages.

Conclusion

The findings of this work can inform both high-level policymakers and international organizations to consider their conceptualization(s) of health equity and subsequently steer their efforts as desired. High-level policymakers can engage in meaningful discussions to reach consensus on how to design public policy that improves the determined collective notion of health equity. Our work can also guide international organizations to consider their underlying intentions and aims of addressing health equity and ensuring alignment between their values and goals and those of their member states. As such, we recommend that the WHO endorse similar studies across its other five remaining regions.

This work can also be used to catalyze further efforts to build on momentum in the region, particularly in

considering COVID-19 as a catalyst [36] and the opportunity it presents to act on health equity [37], given that the pandemic has led to disproportionate impacts and subsequent illumination of inequities [38].

Abbreviations

QALY	Quality-Adjusted Life Year
Urban HEART	Urban Health Equity Assessment and Response Tool
WHO	World Health Organization

Supplementary Information

The online version contains supplementary material available at https://doi.org/10.1186/s12910-024-01154-5.

Supplementary Material 1

Acknowledgements
The authors acknowledge the WHO Regional Office for Africa for endorsing this study and the peer reviewers for their contributions that allowed for strengthening the article.

Author contributions
MA conducted the analysis and drafted the manuscript. MA, BJ, and JB contributed to manuscript development. All authors read and approved the final manuscript.

Funding
MA's position is funded by the donors to the Mary and Maurice Young Professorship in Applied Ethics. BJ's position is funded by a grant from the Norwegian Research Council (grant number: 303724).

Data availability
The dataset generated and analyzed during this study is not publicly available due to the sensitive information contained and to ensure anonymity of key informants. For further information, please contact the corresponding author.

Declarations

Ethics approval and consent to participate
Harvard University's institutional research board provided ethics exemption for this study (protocol number: IRB21-1176) and informed consent was received from all respondents. This study was performed in accordance with relevant guidelines and regulations.

Consent for publication
Not applicable.

Competing interests
MA reports short-term instances of consulting for the World Health Organization and membership with the World Health Organization Collaborating Centre for Knowledge Translation and Health Technology Assessment in Health Equity. The remaining authors declare that they have no competing interests.

Received: 11 December 2023 / Accepted: 6 December 2024
Published online: 23 December 2024

References

1. Amri M, Jessiman-Perreault M, Siddiqi G, O'Campo A, Enright P, Di Ruggiero T. Scoping review of the World Health Organization's underlying equity discourses: apparent ambiguities, inadequacy, and contradictions. Int J Equity Health. 2021;20(1):70.
2. Amri M, O'Campo P, Enright T, Siddiqi A, Di Ruggiero E, Bump J. B. Probing key informants' views of health equity within the World Health Organization's Urban HEART initiative. BMC Public Health. 2022;22. https://doi.org/10.1186/s12889-022-14395-z.
3. Amri M, Enright T, O'Campo P, Di Ruggiero E, Siddiqi A, Bump JB. Health promotion, the social determinants of health, and urban health: what does a critical discourse analysis of World Health Organization texts reveal about health equity? BMC Global Public Health. 2023;1(1):25.
4. Amri M, Enright T, O'Campo P, Di Ruggiero E, Siddiqi A, Bump JB. Investigating inconsistencies regarding health equity in select World Health Organization texts: a critical discourse analysis of health promotion, social determinants of health, and urban health texts, 2008–2016. BMC Global Public Health. 2024. https://doi.org/10.1186/s44263-024-00106-w.
5. Amri M, Mohamood L, Mansilla C, Barrett K, Bump JB. Conceptual approaches in combating health inequity: a scoping review protocol. PLoS ONE. 2023. https://doi.org/10.1371/journal.pone.0282858.
6. Amri M, Siddiqi A, O'Campo P, Enright T, Di Ruggiero E. Underlying equity discourses of the World Health Organization: a scoping review protocol. Social Sci Protocols. 2020;3. https://doi.org/10.7565/ssp.2020.2812.
7. Roemer JE. Theories of Distributive Justice. Cambridge, Massachusetts and London, England: Harvard University Press; 1996.
8. Nozick R. Distributive Justice. Philos Public Affairs. 1973;3(1):45–126.
9. Whitehead M. The concepts and principles of equity and health Copenhagen, Denmark: World Health Organization Regional Office for Europe; 1990 [18]. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.196.7167&rep=rep1&type=pdf
10. Hodgson H. Theories of Distributive Justice: Frameworks for Equity. J Australasian Tax Teachers Association. 2010;5(1):86–116.
11. Hare RM. Moral thinking: its levels, Method, and point. Oxford University Press; 1981. 01 Nov 2003.
12. Tännsjö T. Hedonistic utilitarianism. Edinburgh University; 1998.
13. Parfit D. Reasons and persons. Oxford University Press; 1984. 311 – 27.
14. Rawls J. A theory of justice revised Edition. Harvard University Press; 1999.
15. Trygve O. Lifetime QALY prioritarianism in priority setting. J Med Ethics. 2013;39(3):175.
16. Hirose I, Egalitarianism. Routledge: Taylor & Francis Group; 2015.
17. Nussbaum MC. Creating capabilities the Human Development Approach. Harvard University Press; 2011.
18. Mugumbate, J.R. & Chereni, A. Now, the theory of Ubuntu has its space in social work. Afr J Social Work. 2020.
19. Eze MO. What is African communitarianism? Against Consensus as a regulative ideal. South Afr J Philos. 2008;27(4):386–99.
20. Jecker NS, Atuire CA, Kenworthy N. Realizing Ubuntu in global health: an African approach to global health justice. Public Health Ethics. 2022;15(3):256–67.
21. Mboti N. May the real Ubuntu please stand up? J Media Ethics. 2015;30(2):125–47.
22. Praeg L. An answer to the question: what is [ubuntu]? South Afr J Philos. 2008;27(4):367–85.
23. DeepL. n.d. [https://www.deepl.com/en/translator
24. Tumusiime P, Karamagi H, Titi-Ofei R, Amri M, Seydi ABW, Kipruto H et al. Building health system resilience in the context of primary health care revitalization for attainment of UHC: proceedings from the Fifth Health Sector Directors' Policy and Planning Meeting for the WHO African Region. BMC Proceedings. 2020. https://doi.org/10.1186/s12919-020-00203-2.
25. Karamagi H, Titi-Ofei R, Amri M, Zombre S, Kipruto H, Binetou-Wahebine Seydi A, et al. Cross country lessons sharing on practices, challenges and innovation in primary health care revitalization and universal health coverage implementation among 18 countries in the WHO African Region. PAMJ. 2022;41:159.
26. Smith MJ, Thompson A, Upshur REG. Public health as social justice? A qualitative study of public health policy-makers' perspectives. Soc Justice Res. 2019;32(3):384–402.
27. Amri M, Chatur A, O'Campo P. Intersectoral and multisectoral approaches to health policy: an umbrella review protocol. Health Res Policy Syst. 2022;20(1):21.
28. Amri M, Chatur A, O'Campo P. An umbrella review of intersectoral and multisectoral approaches to health policy. Soc Sci Med. 2022;315:115469.
29. Amri M, Ali S, Jessiman-Perreault G, Barrett K, Bump JB. Evaluating healthy cities: a scoping review protocol. PLoS ONE. 2022;17(10):e0276179.
30. Amri M. Healthy governance for cities: synergizing Health in all policies (HiAP) and healthy cities approaches. J Urb Health. 2022. https://doi.org/10.1007/s11524-022-00618-6.

31. Fricker RD, Schonlau M. Advantages and disadvantages of internet research surveys: evidence from the literature. Field Methods. 2002;14(4):347–67.
32. Omosa O, Archibald T, Niewolny K, Stephenson M, Anderson J. Towards defining and advancing 'Made in Africa evaluation'. Afr Evaluation J. 2021;9(1):564.
33. Chilisa B, Major TE, Gaotlhobogwe M, Mokgolodi H. Decolonizing and indigenizing evaluation practice in Africa: toward African relational evaluation approaches. Can J Program Evaluation. 2016;30(3):313–28.
34. Abimbola S. The foreign gaze: authorship in academic global health. BMJ Global Health. 2019;4(5):e002068.
35. Plamondon K, Bisung E. The CCGHR principles for global health research: centering equity in research, knowledge translation, and practice. Soc Sci Med. 2019;239. https://doi.org/10.1016/j.socscimed.2019.112530.
36. Amri MM, Drummond D. Punctuating the equilibrium: an application of policy theory to COVID-19. Policy Des Pract. 2021;4(1):33–43.
37. Amri MM, Logan D. Policy responses to COVID-19 present a window of opportunity for a paradigm shift in global health policy: an application of the multiple streams Framework as a heuristic. Glob Public Health. 2021;16(8–9):1187–97.
38. Carducci BKE, Amri M, Plamondon KM, Shoveller J, Ako O et al. Prioritizing gender equity and intersectionality in Canadian global health institutions and partnerships. PLOS Global Public Health. 2022;1(10). https://doi.org/10.1371/journal.pgph.0001105.

Publisher's note