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Rawls's Justice as Fairness and Public Health Policy in India: Evaluating Equity after Liberalization

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Introduction

The economic liberalization initiated in India in 1991 marked a watershed moment, transitioning the nation from a protectionist, state-led model to a market-oriented economy (Ahluwalia, 2002; Panagariya, 2008). While this structural shift catalyzed unprecedented GDP growth and technological advancement, its impact on the social sector—specifically public health—has been a subject of intense normative debate. In a society characterized by deep-seated socio-economic hierarchies of caste, class, and geography, the distribution of health services is not merely a logistical challenge but a fundamental question of social justice. As the private healthcare sector expanded rapidly in the post-liberalization period, the public health system faced challenges of underfunding and fragmentation, leading to high out-of-pocket expenditures that push millions into poverty annually (Selvaraj et al., 2022; Berman, Ahuja & Bhandari, 2010).

To evaluate the ethical implications of these reforms, this paper utilizes John Rawls's seminal theory of Justice as Fairness. Rawls posits that justice is the "first virtue of social institutions" and provides a normative framework to evaluate whether social inequalities are morally justifiable. Central to this study is the application of the Difference Principle, which mandates that any departure from absolute equality is permissible only if it results in the greatest benefit for the least advantaged members of society (Rawls, 1971). In the Indian context, health is treated as a primary social good because, as Norman Daniels (2008) argues, health is essential for maintaining fair equality of opportunity.

The objective of this paper is to examine whether post-liberalization health policies, such as the National Health Policy 2017 and the Ayushman Bharat Mission, align with these Rawlsian ideals (Government of India, 2017; National Health Authority, 2018). By employing a Rawlsian Grid, the study evaluates the shift from state provisioning to strategic purchasing and its consequences for distributive justice. Ultimately, the paper argues that while recent financial protection schemes partially address the requirements of the Difference Principle, persistent infrastructural gaps and regional disparities continue to undermine the Rawlsian promise of a fair and just health system for all Indian citizens.

Objectives of the Study

The research is systematically guided by the following objectives, aimed at bridging the gap between normative political theory and empirical health policy analysis:

1. Theoretical Examination: To examine the theoretical relevance of John Rawls's "Justice as Fairness" as a moral and analytical lens for evaluating public health policy.
2. Impact Assessment: To analyze the impact of post-liberalization health sector reforms on equity, accessibility, and financial protection within the Indian socio-economic landscape.
3. Evaluating the Difference Principle: To assess whether current public health policies—specifically strategic purchasing and insurance-led models—benefit the "least advantaged" groups in accordance with Rawls's Difference Principle.

4. Operationalization: To operationalize Rawls's abstract principles into a practical evaluative framework, termed a "Rawlsian Grid," suitable for context-sensitive policy analysis.
5. Institutional Review: To identify the critical institutional, infrastructural, and governance constraints that impede the realization of equitable health outcomes in India.
6. Normative Proposals: To propose specific normative and policy recommendations aimed at strengthening distributive justice and fulfilling the promise of "fair equality of opportunity" in India's health system

Literature Review : The Ethical Dimensions of Health Equity

The discourse on health equity has evolved significantly from viewing health as a mere biological state to recognizing it as a product of social and political arrangements (WHO, 2008; Marmot, 2015). Central to this literature is John Rawls's A Theory of Justice, which provides the bedrock for contemporary debates on distributive justice. However, applying Rawlsian theory to public health requires navigating several decades of academic expansion and critique (Daniels, 2008; Sen, 2002).

• The Rawlsian Foundation and the Problem of "Natural Goods"

In his original formulation, Rawls distinguished between social primary goods (rights, liberties, income and wealth) and natural primary goods (health, intelligence, vigor). He argued that while social goods are directly distributed by the basic structure of society, natural goods are influenced by social arrangements but are not directly under institutional control. This created an early theoretical hurdle for health policy analysts: if health is a product of the "natural lottery," can it legitimately become a matter of distributive justice? (Rawls, 1971; Daniels, 2008).

Contemporary literature largely agrees that Rawls's initial hesitation underestimates the extent to which social institutions shape health outcomes (Daniels, 2008; Marmot, 2015). In post-liberalization India, the "natural lottery" of health is deeply mediated by structural inequalities in nutrition, sanitation, education, and public service delivery (Rao, 2017; Dreze & Sen, 2013). For example, stunted growth among children in rural and tribal regions is empirically linked to institutional failures in food security and public health infrastructure rather than genetic endowment alone (NFHS-5, 2021).

• The Daniels Extension: Health and Opportunity

Norman Daniels (2008) offers the most influential extension of Rawlsian theory to the health sector in his work Just Health. Daniels argues that because illness and disability restrict an individual's "normal range of opportunities," protecting health becomes morally necessary to preserve Fair Equality of Opportunity (FEO) (Daniels, 2008).

In the Indian context, where access to quality healthcare is increasingly mediated by market forces, inequitable health outcomes directly constrain social mobility (Baru, 1998; Srinivasan, 2021). If an individual from a Scheduled Caste (SC) or Scheduled Tribe (ST) community is incapacitated by a preventable disease, their effective freedom to participate in education or the labor market is structurally curtailed (Thorat & Newman, 2010; Rao, 2017). Literature examining India's neoliberal transition notes that when healthcare becomes commodified, opportunities cease to be "fair" because access becomes contingent upon purchasing power, thereby violating Daniels's Rawlsian principle of equal opportunity (Srinivasan, 2021; Daniels, 2008).

• The Capabilities Approach: Sen's Critique of Rawls

A substantial body of literature contrasts Rawlsian "resourcism" with Amartya Sen's (2002) Capabilities Approach. Sen contends that justice should focus not merely on the distribution of primary goods but on individuals' real capabilities to achieve valuable functionings (Sen, 2002; Robeyns, 2005).

For instance, the mere provision of a health insurance card (a resource) may not translate into improved health outcomes (a capability) for women in patriarchal households if mobility, autonomy, or information access remains constrained (Sen, 2002; Desai & Andrist, 2010). Nevertheless, for policy evaluation in India, Rawlsian analysis remains analytically powerful because it enables critique of the basic structure of institutions rather than only individual conversion factors. This allows scholars to interrogate systemic distortions such as disproportionate investment in urban tertiary care at the expense of rural primary healthcare (Rao, 2017; Baru, 1998).

• Health Policy in Post-Liberalization India: The Equity Gap

Literature on India's post-1991 reforms consistently identifies the emergence of a dualistic health system characterized by a growing private sector and a weakened public provisioning role (Baru, 1998; Nundy et al., 2019). Liberalization encouraged what scholars describe as the "commercialization of care," leading to escalating out-of-pocket expenditure and the phenomenon of Catastrophic Health Expenditure (CHE) (Berman et al., 2010; Selvaraj et al., 2022).

Recent evaluations of Ayushman Bharat (PM-JAY) examine whether the model of strategic purchasing aligns with the Rawlsian Difference Principle. Some scholars argue that PM-JAY represents the first large-scale attempt to explicitly prioritize the least advantaged populations through financial risk protection (Bakshi et al., 2021; National Health Authority, 2020). However, critics caution that without simultaneous strengthening of public health infrastructure, the scheme risks channeling public funds toward private providers, thereby failing to transform the underlying basic structure necessary for sustainable distributive justice (Baru, 1998; Nundy et al., 2019).

Methodology

This study uses a qualitative normative policy analysis to examine public health policy through a Rawlsian framework (Rawls, 1971; 1999). Rather than primary surveys, it adopts a philosophical–evaluative approach.

Research Design

The study follows two stages: (i) conceptual analysis of Justice as Fairness, focusing on the Difference Principle and Fair Equality of Opportunity, with health treated as a primary social good (Daniels, 2008); and (ii) comparative review of India's pre- and post-liberalization health policies to assess distributive shifts and equity outcomes (Baru et al., 2010).

Data Sources

The analysis relies solely on secondary data: NFHS-5 for demographic outcomes (IIPS & ICF, 2021), National Health Accounts for expenditure trends (Government of India, 2022), official policy documents including National Health Policy 2017 and Ayushman Bharat

guidelines (MoHFW, 2017; 2018), and peer-reviewed literature on health governance and distributive justice.

Evaluative Framework

A Rawlsian Grid evaluates policy outcomes across three dimensions—Liberty, Opportunity, and Difference—to assess alignment with distributive fairness and justice principles (Rawls, 1971; Daniels, 2008).

Conceptual Framework : Rawlsian Grid for Health Policy Analysis

This study operationalizes Rawls's Justice as Fairness (1971) through a structured Rawlsian Grid for health policy evaluation. Moving beyond econometric indicators, it emphasizes distributive equity and institutional justice to assess India's post-liberalization health system across three dimensions.

Dimension I : Liberty and Access

Based on the Liberty Principle, this dimension examines the right to healthcare and removal of access barriers. It evaluates whether post-1991 privatization limits positive liberty for marginalized groups and identifies justice deficits when care depends on ability to pay rather than need (Baru et al., 2010; NFHS-5; NHA).

Dimension II : Fair Equality of Opportunity

Since health shapes life chances, this dimension assesses regional and social disparities, especially rural–urban gaps and workforce distribution (Daniels, 2008). If birthplace or social status determines survival, FEO is violated. It reviews whether policies like the National Health Mission correct these inequalities (IIPS & ICF; MoHFW).

Dimension III : Difference Principle

This dimension applies the Difference Principle to schemes such as Ayushman Bharat, examining whether public–private models benefit the least advantaged or shift public resources toward private providers (MoHFW; Government of India; NFHS-5; NHA).

The Rawlsian Grid provides a normative basis to critique healthcare commodification and prioritize justice in health governance (Rawls, 1971; Daniels, 2008).

Analysis and Discussion : Navigating the Market-Equity Paradox

1. The Difference Principle and the "Purchaser" Model (PM-JAY)

Ayushman Bharat (PM-JAY) targets the bottom 40% of the population, reflecting a clear Rawlsian intent to prioritize the "least advantaged" (Rawls, 1971). By shifting the state's role from a provider to a "strategic purchaser," the government aims to reduce catastrophic health expenditure through insurance-led interventions (MoHFW, 2018).

Expanded Analysis: However, the Difference Principle requires that the outcome must be to the greatest benefit of the poor. Secondary data reveals a significant "Institutional Gap"; in states like Bihar and Uttar Pradesh, the concentration of empanelled private hospitals in urban centers means rural beneficiaries often have the "insurance card" but no "physical facility" within reach (National Health Mission, 2022).

Discussion on Reciprocity: Beyond mere access, a Rawlsian critique must address the "reciprocity" of this model. When public tax money is funneled into private corporate hospitals via insurance premiums, it creates a regressive redistribution of wealth if those hospitals do not provide a corresponding level of social value beyond profit-making. In a truly just society, the "purchaser" model should be a temporary bridge to strengthen public infrastructure, not a permanent substitute that leaves the state-run primary care system in a state of terminal neglect.

2. Fair Equality of Opportunity and the "Birthplace Lottery"

Rawlsian justice mandates that an individual's life prospects should not be determined by the "natural lottery" of their birth (Rawls, 1971). In a just system, health—as a foundational good—must be distributed in a way that levels the playing field for all citizens regardless of their geographical origin.

Expanded Analysis: NFHS-5 data exposes a stark "Geographical Lottery" that persists decades after liberalization (NFHS-5, 2021). A child born in Kerala has access to a robust three-tier public health system, resulting in an Infant Mortality Rate (IMR) comparable to developed nations, whereas a child in an "Aspirational District" of Madhya Pradesh faces significantly higher risks (Registrar General of India, 2021).

Discussion on Systemic Parity: This regional neglect is a direct violation of Fair Equality of Opportunity (FEO). From an academic standpoint, the post-liberalization focus on "Medical Tourism" and urban tertiary care has created "Islands of Excellence" amidst a "Sea of Deprivation" (Kumar, 2019). For health to be a "fair opportunity," the state must ensure that a PHC (Primary Health Centre) in a tribal block offers the same diagnostic quality as an urban dispensary. Without this "supply-side" parity, liberalization merely offers the illusion of choice to those whom the geography has already marginalized.

3. Intersectionality: Caste as a Barrier to Social Primary Goods

Caste remains a structural "arbitrary contingency" in India that Rawlsian justice must actively mitigate (Deshpande, 2011). The social hierarchy often dictates not just economic status but also the level of dignity and quality of care an individual receives within clinical settings.

Expanded Analysis: Analysis of secondary data indicates that Scheduled Caste (SC) and Scheduled Tribe (ST) communities consistently report the highest Out-of-Pocket Expenditure (OOPE) relative to their household income (NSSO, 2019). In a liberalized market, health becomes a commodity where "choice" is a liberty reserved for those with both financial and social capital.

Discussion on Social Exclusion: The discussion must recognize that caste acts as an "unseen gatekeeper." Even when services are technically "free," the social distance between the provider (often from a privileged background) and the marginalized patient can lead to "dignity deficits." A Rawlsian framework suggests that "Justice as Fairness" is incomplete without Institutional Sensitivity (Rawls, 1971).

Therefore, health policy must transition from "neutral" schemes to "pro-poor" affirmative actions that address the historical mistrust and systemic exclusion faced by marginalized castes in the medical marketplace.

4. The Digital Divide: The New Frontier of Exclusion

The Ayushman Bharat Digital Mission (ABDM) introduces technological variables into the Rawlsian Grid, aiming to streamline health records and improve efficiency through a unified digital identity (MoHFW, 2021).

Expanded Analysis: While digitalization promises efficiency, the "Digital Divide" creates a new layer of institutional exclusion (IAMAI, 2020). Behind a "Veil of Ignorance," no rational agent would design a system where life-saving treatment or diagnostic access is contingent upon smartphone ownership or biometric authentication.

Discussion on Technological Justice: Technology in a developing economy must be judged by its impact on the "least advantaged." If digital registries lead to "Aadhaar-based exclusions" or "authentication failures" in remote areas with poor connectivity, the efficiency

gained for the state comes at the cost of the citizen's basic liberty. A Rawlsian approach demands a "Human-Centric Digitalization" where digital tools are used to find the underserved, rather than requiring the underserved to navigate complex digital portals to prove their eligibility for care.

5. Commercialization vs. The Social Contract

The most profound shift since 1991 has been the gradual commodification of healthcare, moving it from the realm of a "Social Contract" to a "Commercial Contract" (Berman, 1995). This shift reflects a move toward market efficiency, often at the cost of normative equity.

Expanded Analysis: With India's OOPE standing at nearly 48% (World Bank, 2020), health is increasingly treated as an "earned good" rather than a fundamental right. Rawlsian justice is founded on the idea of social cooperation for mutual benefit, where certain "primary goods" are insulated from the market (Rawls, 1971).

Discussion on the Moral Minimum: The retreat of the state to a mere "purchaser" role erodes the moral foundation of the social contract. When healthcare is commodified, the "Basic Structure" of society prioritizes profit-maximizing efficiency over human-centered equity. To restore "Justice as Fairness," India must re-establish health as a foundational social good. This involves an ethical commitment to a "Moral Minimum" of care that is guaranteed to every citizen, regardless of their position in the economic hierarchy, thereby re-asserting the state's duty as the primary custodian of public life.

Conclusion and Policy Recommendations

The evaluation of India's post-liberalization health trajectory through the lens of John Rawls's "Justice as Fairness" reveals a complex dualism. While the state has transitioned from a passive provider to an active "strategic purchaser" through schemes like Ayushman Bharat (PM-JAY), the fundamental "Basic Structure" of healthcare remains skewed against the "least advantaged." This study, utilizing the Rawlsian Grid, concludes that although financial protection has improved, the "Fair Equality of Opportunity" (FEO) is still compromised by geographical, digital, and social barriers. The transition to a market-led model has achieved technological efficiency but at the cost of distributive equity, leaving the "birthplace lottery" as a dominant determinant of an Indian citizen's right to life.

- Policy Recommendations for Strengthening Distributive Justice

To align India's healthcare system with the normative ideals of justice, the following structural and policy shifts are proposed:

Mandatory Universal Health Coverage (UHC) Transition: To fulfill the Liberty Principle, the state must decouple healthcare from ability to pay. India should move toward a tax-funded, single-payer UHC model. This would ensure that health is treated as a "Primary Social Good" rather than a market commodity, effectively reducing out-of-pocket expenditure (OOPE) that pushes millions into poverty.

Implementation of a Weighted "Equity Budget": Following the Difference Principle, resource allocation must be positively discriminatory. Instead of uniform funding, a weighted budgetary mechanism should be adopted where Aspirational Districts and tribal blocks receive higher per-capita funding. This Equity Budgeting corrects the historical neglect of public healthcare in marginalized regions.

De-commodifying Primary Care via HWCs: The 1.5 lakh Health and Wellness Centres must be strengthened as primary gatekeepers of justice. By ensuring free diagnostics, essential medicines, and preventive care at the village level, the state can restore Fair Equality of

Opportunity. Strengthening supply is essential to ensure insurance coverage translates into actual medical services.

Institutional Regulation and Moral Accountability: The state must move beyond being a mere purchaser to a robust regulator. Implementing the Clinical Establishments Act and regulating private pricing protects the least advantaged from information asymmetry in laissez-faire healthcare markets. Social audits of hospitals should ensure compliance with moral obligations under the social contract.

- Final Synthesis

In conclusion, a just society is not measured by its total wealth, but by how it treats its most vulnerable members. Behind the "Veil of Ignorance," no rational citizen would choose a system where health is a privilege of the urban elite. For India to bridge the gap between its economic ambitions and its ethical commitments, it must reposition health as a foundational social good. Only by prioritizing "Fairness" over "Profitability" can India fulfill the promise of a democratic republic where every citizen has an equal opportunity to lead a healthy and dignified life.

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