

Section 2

Issues

Chapter

12

Health inequities

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Introduction

The infant mortality rate (IMR) in Liberia is 50 times higher than it is in Sweden, while a child born in Japan has a life expectancy at birth of more than double that of one born in Zambia (Central Intelligence Agency, 2007).¹ And within countries, we see differences that are nearly as great. For example, if you were in the USA and travelled the short journey from the poorer parts of Washington to Montgomery County Maryland, you would find that 'for each mile travelled life expectancy rises about a year and a half. There is a twenty-year gap between poor blacks at one end of the journey and rich whites at the other' (Marmot, 2004: 2).

There are two types of questions that it is important to ask about inequalities in health such as these. The first are social scientific questions about the extent of inequalities in health and the factors which are causally responsible for these inequalities. Examples of social scientific questions to ask might be: how do infant mortality rates in the UK differ according to social class? What is the difference in life expectancy between Japanese who emigrate to the USA and those who remain in Japan? Why do civil servants in higher ranked jobs tend to live longer than civil servants in lower ranked jobs?

The second type are normative questions about the reasons we have to care about inequalities in health. Important normative questions to answer are: which inequalities in health should we care about (all inequalities or merely some of them)? When is an inequality in health unjust? How should we weigh our concern for equality in health against other factors such as maximizing the health achievement of community?

This chapter focuses on these normative questions. But I shall first briefly outline some of the main findings of the social sciences literature in order to put the normative questions in the right perspective. Much of the relevant literature has focused on the relationship between socio-economic status (SES) and health achievement, and I shall follow this lead in my summary.

The gradient in health

There is evidence of a socio-economic gradient in health in all countries for which statistics are available. In other words, as a person's SES increases, so her life expectancy

¹ The infant mortality rate in Liberia is 149.73 per 1,000; in Sweden it is 2.76. The life expectancy at birth in Japan is 82; in Zambia it is 38.4 (Central Intelligence Agency, 2007).

improves and so also do a range of other important health indicators.² The gradient is by no means confined to groups who suffer absolute deprivation. It also occurs within groups who are in absolute terms, fairly well off. For example the famous Whitehall studies showed a gradient in health among civil servants, all of whom were, in absolute terms, comfortably off (Marmot *et al.*, 1978). So it is not just that that ‘the poor’, as a group have worse health, but also that, as we go up the social scale, each rung we ascend will increase life expectancy, and decrease the chance of developing many diseases, such as stroke or heart disease.³

The socio-economic gradient in health is less steep in some countries than in others (and also changes in severity in the same countries over time), which suggests that there must be social factors that can either flatten gradients or make them more vertiginous. And if the socio-economic gradient in health has social causes, then it seems plausible to think that it will be in our power to flatten it if we want to.

Does low socio-economic status cause ill health?

The correlation between low SES and ill health is robust. However, correlation is not causation. It does not follow logically from the fact that people with low SES tend to have worse health and lower life expectancies that having a low SES *causes* ill health. For all that we have so far seen, it might be ill health that causes low SES, or it might be that there is some further factor that causes *both* low SES *and* ill health, while neither low SES nor ill health cause one another.

Many people think that the direction of causation of health inequalities is important, because they think that it is morally worse if an inequality in SES causes an inequality in health, than if an inequality in health causes an inequality in SES. As Daniels *et al.* (2004: 63) put it, ‘Many who are untroubled by some kinds of inequality are particularly troubled by health inequalities. They believe that a socio-economic inequality that otherwise seems just becomes unjust if it contributes to health inequalities.’ Because of this, much of the social sciences literature on health inequalities has been devoted to establishing that it is low SES which is responsible for poor health, rather than vice versa.

No one disputes that *some* of the correlation between SES and health is caused by the effects of ill health. For example, it is very plausible to think that, as a group, people

² The term SES is usually used to refer to ‘the relative position of a family or individual on a hierarchical social structure, based on their access to or control over wealth, prestige and power’ (Mueller and Parcel, 1981). However, when defined in this way SES is difficult to measure accurately and so studies tend to use something easier to measure as a proxy for SES. Popular candidates for proxy measures include level of education, current income, overall wealth, type of occupation or some combination of these measures (Shaver, 2007). Each of these measures has their advantages and disadvantages, and clearly the fact that different studies use different measures creates a degree of difficulty in comparing the results of different studies examining the relationship between SES and health (Braveman *et al.*, 2005). However the finding that there is a correlation between SES and health is sufficiently robust that it holds whichever way we measure SES, so I shall set this problem of measurement aside here.

³ There are some (very few) conditions, such as breast cancer in European countries, which show a reverse socio-economic gradient. (A possible explanation for the reverse economic gradient in breast cancer is that having children later increases risk of breast cancer, and women with a higher SES tend to have children later. See Strand *et al.*, 2007.)

who are unable to work because of chronic illness will tend to have a lower income than people who are able to work. The interesting question is whether *all* (or even most) of the socio-economic gradient in health can be explained in this way. And in fact the evidence shows that the effects of this 'health selection' are fairly small in comparison to the overall size of the socio-economic gradient.⁴

Of course, there are other factors which might explain the correlation. One obvious factor could be that it is inequalities in access to health care which explain the social gradient in health. However, this does not seem to be a very significant cause of variation in health, given that we see a significant social gradient in health even in countries such as the UK, which have a nationalized health system. Another factor could be intelligence: it might be the case that more intelligent people will tend to do better in their jobs, and also will tend to take more health preserving behaviours than less intelligent people, so that intelligence will tend to influence both SES and health. Ultimately, though the question remains whether we can plausibly account for *all* the correlation of health and SES without allowing that low SES causes a significant proportion of the variation in health. And it seems that we cannot.

In addition, we have a number of possible models which seek to explain *how* low SES could cause ill health, by explaining how the social factors associated with lower SES could have a bad effect on health. Marmot (2004) hypothesizes that people of a lower SES tend to have less control over their working and living environments, and that this sense of lack of control leads to stress responses, which predictably cause conditions such as atherosclerosis and obesity. Wilkinson (1996) argues that it is income inequality that is the key factor which affects the size of the socio-economic gradient, and that other things being equal, the health of *all* members of society tends to be worse in an unequal society. This suggests that goods such as social capital and social cohesion play a role in governing health states – presumably ultimately via similar causal pathways to those hypothesized by Marmot.

There is very much more that could be said about the social sciences literature, in particular on the question of how low SES causes ill health. However, our focus is on the normative questions that arise about health inequalities, and as we shall see below, there is good reason to think that these questions of causation are only of tangential relevance to the fundamental normative question of which inequalities in health are unjust.

From social science to political philosophy

Until fairly recently, there was little interaction between social scientists working on the extent and causes of health inequalities and political philosophers seeking to answer normative questions about which inequalities are unjust. One reason for this was a failure (by both sides) to see how materials produced by the other could be relevant to the questions that they were asking. For instance, it is notable that Rawls, the most influential political philosopher of the second part of the twentieth century, scarcely addresses health at

⁴ For example, Chandola *et al.* (2003) argue that in the Whitehall study, the data show that the effect of social position on health was over two and a half times greater than the effect of health on social position. Clearly the size of the causal effect of health on SES will vary from country to country and from situation to situation, depending on the level of support a society provides for those unable to work through illness. But nowhere is it plausible to attribute *all* the socio-economic gradient in health to health selection.

all, and where he does, questions of inequalities in health do not even enter onto his radar.⁵ Meanwhile, Marmot (2004), who has done more than anyone to raise and to answer the social scientific questions, reports that it was only fairly recently that he realized that the normative implications of his work on inequality in health had already been separately explored at length by political philosophers.⁶

However, recent times have seen a change. Workers within empirical fields are becoming increasingly aware of the role that ethical thinking and particularly political philosophy can play, while political philosophers have become increasingly aware of the relevance of the social scientific literature. One of the major aims of this chapter is help to strengthen this dialogue.

The concept of a health inequity

Before going any further, we must make an important distinction between health *inequalities* and health *inequities*. I shall take health inequalities to be ‘the generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups,’ (Kawachi *et al.* 2002: 647), while I shall take health inequities to be those health inequalities that are, all things considered, unjust.

We need to make this distinction because it is plausible to think that there are at least some inequalities in health that are not unjust. And where an inequality is not unjust, it would be wrong to think that we have a duty to alleviate it or eliminate it.⁷ To give an example, a recent study of 1000 major European and North American pop stars 1956–2005 revealed that they ‘experience significantly higher mortality (more than 1.7 times) than demographically matched populations in the USA and UK’ (Bellis *et al.*, 2007: 896), thus showing a significant health inequality between pop stars and the ordinary members of the public. But I think that few would feel that the researchers had thereby uncovered an inequity that the European and US governments should be in a hurry to address, given that pop stars’ decreased life expectancy seems to be due in large part to their choices to adopt high-risk behaviours.

When dealing with concepts such as that of a health inequity, which imply a normative judgement about those things that fall under them, it is often useful to begin by clarifying the role that we think the concept should play before going on to specify which things should fall under the concept. For it is usually much easier to get a consensus on the role

⁵ There is one passage which is particularly telling, where Rawls allows that health is equally as important a good as the primary goods which his theory of justice picks out to be distributed fairly. However he denies that we should treat health as one of the primary goods, on the grounds (1) that it is ‘natural’ rather than a social good (meaning that it is much less closely affected by changes in the basic structure of society than are the genuine primary goods such as rights, liberties and opportunities, income and wealth, and the social bases of self-respect), and (2) his theory of justice concerns only the justice of the basic structure of society (1971: 62). While this was a reasonable view of health to hold in 1971, the mass of literature produced on the social determinants of health over the past thirty years has clearly demonstrated that (1) is false. Rawls seems never to have revised his views to take account of the social determinants of health.

⁶ As he (2004: 38) puts it, ‘I read for the first time [in 1998], Amartya Sen’s writings on Inequality . . . I felt like the man who had discovered he had been talking prose. I was intrigued to discover that some of the conclusions towards which my colleagues and I had been struggling towards on the basis of our evidence, were elegantly laid out there.’

⁷ Of course, it would not necessarily be wrong to alleviate or eliminate it. My point is simply that we would not be *obliged* to do so.

that a normative concept should play than to get a consensus on what things should fall under that concept, and once we have this consensus it is easier to understand and to adjudicate the disputes that will then inevitably arise about which things should fall under the concept. So the rest of this section aims to clarify the role that the *concept* of a health inequity should play.

I shall briefly examine the two most influential definitions of a health inequity, the first by Whitehead Dahlgren (1992, 2006; Whitehead, 1990), and the second by Kawachi *et al.* (2002). I shall argue that neither is adequate, and will suggest a more precise definition.

In a widely cited article, Whitehead (1990: 5) defines health inequities as differences in health which are ‘unnecessary and avoidable but, in addition are also considered unfair and unjust’.⁸ Whitehead does not provide much by way of an explanation as to why the differences should have to be ‘unnecessary and avoidable’ as well as unjust, and it seems to me that these additional qualifications are unhelpful. For if we already thought that a given health inequality was unjust, we would usually be taken to be already making the claim that it amounted to a health inequity. So I do not think that being also told that the inequality was ‘unnecessary and avoidable’ would add anything. Conversely, if we did not know whether a difference in health was inequitable, discovering that the difference was unnecessary and avoidable would not provide a reason in and of itself to think that the difference in question was inequitable. For instance, when competent adults undertake dangerous sports such as mountaineering, they knowingly increase their risk of death and injury. This increased risk creates a health inequality between mountaineers and non-mountaineers which is unnecessary and avoidable, but not unjust (and hence not inequitable) (Kawachi *et al.* 2002: 648). So at the very least, adding the claims that the differences have to be ‘unnecessary and avoidable’ adds nothing to the definition of health inequity.

However, things are worse than this. The assumption that health inequities by definition are ‘unnecessary and avoidable’ has led Whitehead and Dahlgren and those who have followed them to make some very implausible claims about what kinds of things could and could not count as health inequities. Whitehead and Dahlgren’s (2006: 2) underlying thought seems to be that it is only where ‘social processes . . . produce health differences rather than these being determined biologically’, that it makes sense to say that there is a health inequity, and that hence only inequalities which are caused by *social* as opposed to *natural* factors are even candidate health inequities. Their argument for this claim seems to be as follows:

Human beings vary in health as they do in every other attribute. We will never be able to achieve a situation where everyone in the population has the same type and degree of illness and dies after exactly the same life span. This is not an achievable goal, nor even a desirable one. Thus, that portion of the health differential attributable to natural biological variation can be considered inevitable rather than inequitable.

(Whitehead, 1990: 6–7)

The thought seems to be that inequalities which are due to human activity are avoidable *because* they are caused by human action, whereas inequalities caused by nature are not

⁸ It is unclear why there is a reference to differences which are *both* unfair *and* unjust, given that she does not make any distinction between these two terms, which are in any case close to synonymous in ordinary usage. I shall assume that we should delete unfair, and simply leave ourselves with the idea of *unjust* differences.

caused by human action and so we are powerless to do anything about them. There are two mistakes contained in this: first, it does not follow that just because something has a social cause that we will be able to successfully stop it by social intervention. (It is by no means clear that we will be able to stop climate change, for instance.) Second, it does not follow from the fact that something is caused by 'nature' either that we are either powerless to stop it, or that we should refrain from trying to stop it. (Presumably all of medicine could legitimately count as trying to stave off what would otherwise be the inevitable operation of nature, as John Stuart Mill [1874] points out.)

Moreover the conclusion does not follow from the premises. For, even if it would be unjust and undesirable to attempt to equalize health achievement across a society, it would not follow that people who are born with worse health have *no* claim to some form of rectification on grounds of justice. For example, we may not be in a position to give someone who is blind sight, and clearly it would be undesirable to blind the rest of the population to restore equality. But there are other things we can do, such as ensuring that buildings are arranged for easy navigation by blind people, or ensuring that all official documents are available in braille, which many people take to be required by justice. Hence the fact that we cannot alleviate blindness does not mean that we have to say that it is merely down to 'nature', and that the disadvantage to the blind person should be considered inevitable rather than inequitable.

Further, much of the mainstream philosophical writing on justice over the last 30 years has taken it as axiomatic that undeserved disadvantages due to bad luck (such as being born blind, or without the use of one's legs, or having a very low life expectancy) *do* raise issues of justice, and that undeserved disadvantages of this kind give the affected individuals claim for rectification under egalitarian justice. This position has now come to be known as 'luck egalitarianism'. See for example, Dworkin (1981a, 1981b), Arneson (1989) and Cohen (1989). For critiques of this position, see Anderson (1999) and Scheffler (2003).

This means that Whitehead and Dahlgren must either allow that health inequities account for only some of the inequalities in health achievement which a just society should be concerned about, or they must be committed to the claim that luck egalitarianism's central claim is false, and that in fact it is only inequalities with a social cause which are of concern for egalitarian justice. Both of these options seem inappropriate for an account of the *concept* of a health inequity. Absent any account of why we should treat unjust inequalities with social causes differently from unjust inequalities with natural causes, it looks arbitrary to suggest that we should address them separately. And it would seem to be a mistake to build a controversial claim about the nature of egalitarian justice into our concept of a health inequity. While such controversial positions might be true, they need to be argued for as the *best* accounts of health inequity, rather than simply presupposed as following from the very concept of a health inequity.

Where does this leave us? I take it that the only part of Whitehead and Dahlgren's original definition of a health inequity still standing is the idea of an *unjust* inequality. This idea forms the kernel of the second major definition of health inequity in the literature, namely that 'Health inequity refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice' (Kawachi *et al.*, 2002: 647). This is, I shall suggest, much better, but still in need of a little more refinement.

Kawachi *et al.*'s definition suggests that health inequalities which *stem from* injustice should count as health inequities. However, it is unclear why we should accept this. For not every inequality which stems from an injustice is itself unjust. Some inequalities which stem

from injustices will be trivial and morally insignificant, while other inequalities might even benefit those who have been unjustly treated. (For instance, a society which allowed men, but not women, to smoke would treat women unjustly. However, the health inequalities in women's favour to which this would no doubt lead would not rightly be considered to be health inequities.)

So it seems too strong to suggest, as Kawachi *et al.* seem to, that *all* inequalities which stem from injustice are themselves inequitable. Rather, it is only when an inequality which stems from injustice adversely affects something that we already think we have reason to care about from the perspective of justice, that we think it is unjust. Hence inequalities in health that stem from injustice will count as health inequities only if we already have a reason to think that inequalities in health are something that we ought to care about from the perspective of justice. And we ought to care about inequalities in health from the perspective of justice only if such inequalities are either unjust in themselves or contribute to states of affairs which are unjust in themselves. So if we build into our definition of a health inequity the claim that inequalities in health which stem from injustice are inequitable, we risk begging the question.

It follows, I take it, that a concern with health equity is purely and simply a concern for justice in the distribution of health achievement. So a health inequality is a health inequity if and only if it is an inequality which a just society would seek to counteract. The key question then is *which* health inequalities are unjust?

Two dimensions of egalitarian justice

I shall assume that the correct account of justice is in some broad sense egalitarian, and that a just society should seek to treat all its citizens as equals.⁹ There is a dispute in egalitarian justice as to the appropriate scope of obligations of justice: cosmopolitans such as Pogge (2008) argue that obligations of justice are global, while others such as Rawls (1999) and Nagel (2005) argue that obligations of socio-economic justice fundamentally apply only within societies. We shall not enter into this dispute here, but I should point out that the outcome of this debate will have a major impact on which types of health inequalities could count as inequities. For if there are no strict obligations of global socio-economic justice, then health inequalities between nations will not count as health inequities.

There are two axes along which theories of justice vary. First, there is the 'what' dimension: *what* good or goods need to be distributed fairly to each in order to ensure

⁹ Egalitarianism in this broad sense has come to be central to the way we think about justice. Whereas in former times the idea that some form of *inegalitarianism* – that for example, took men to be worth more than women, white more than black citizens, or rich more than poor was expressed and even defended, the thought that a just society ought to treat all its citizens as equals enjoys overwhelming support today. In Sen's (2004: 22) words, 'a theory of justice in the contemporary world would not have any serious plausibility if it did not value equality in some space – a space that would be seen as important in that theory'. This is not to say that in the world as we encounter it women are *in fact* treated as equals to men; and the poor are *in fact* treated as equals to the rich, but rather that where such things occur they are widely recognized to be unjust. Defending this intuition of fundamental human equality is beyond the scope of this chapter. (I go some way towards defending it in Wilson [2007a, 2007b]). For the best current overview and defence of the idea of fundamental human equality, see Waldron (2000).

that a society is just? Second, there is the ‘how’ dimension: *how* should we distribute those goods which are the appropriate concern of egalitarian justice? (Hurley, 2007).

Cohen (1989: 906) famously labelled the ‘what’ question the question of the currency of egalitarian justice: ‘[w]hat aspects of a person’s condition should count in a *fundamental* way for egalitarians, and not merely as a cause of or proxy for what we regard as fundamental?’. For instance, a crude egalitarian might take financial wealth to be the only currency of egalitarian justice, while more sophisticated egalitarians argue that the relevant currency is opportunity for welfare, or access to advantage.¹⁰ The key normative question for us is whether *health* matters in a fundamental way for egalitarian justice. If it does not, then talk of *health* inequities risks being needlessly imprecise and potentially misleading, given that the relevant inequity will not lie in the maldistribution of health, but rather in the maldistribution of another, more fundamental good. I take up the question of health and egalitarian justice in the following section.

The key question posed by the ‘how’ question is how we should seek to distribute those goods which *are* of fundamental concern for egalitarian justice. There are three main approaches within the broadly egalitarian framework. *Strict egalitarians* take it that our goal (insofar as we are concerned with egalitarian justice) should be to *equalize* the amount of those goods that are of fundamental importance to justice which each person receives. Importantly, strict egalitarians believe that it can be legitimate to ‘level down’ – namely to remove goods which are of fundamental importance from the perspective of justice from those who are better off, just to make the distribution more equal, even if no individual person’s life is made better by this. *Prioritarians* take it that it is not an equal distribution of goods per se which matters, but rather how each individual person is faring relative to how they might be faring. According to the prioritarian, we should give priority (either absolute or weighted) to improving the condition of those who are worst off in the distribution of those goods which are of fundamental importance from the perspective of justice. This avoids the counterintuitive result of levelling down. Lastly, *sufficientarians* take it that what matters from the perspective of justice is that each person have *enough* of the goods that are of fundamental importance for justice, and that once this threshold has been reached, a person has no more claims on justice. As we shall see in below, how to apply these answers to the ‘how’ question to the domain of health is a complex question.

Is health of fundamental importance for egalitarian justice?

It is implausible to think that health is the *only* currency of egalitarian justice. For there seem to be goods which are important to a just society which are neither reducible to fair distribution of health achievement, nor valued only for their contribution to fair distribution of health achievement. For example, it would seem strange to describe a society which was rife with racism and discrimination, and prevented women from voting or from holding political office, but yet where fortuitously everyone had the same level of health

¹⁰ Focusing only on financial wealth is a crude view, first because financial wealth is not important in itself, but rather only important for the goods it gives access to. Second, different people will have different levels of efficiency in converting money into things that do matter for their own sake. (For instance, if we gave the same amount of money to all persons, this money would go much less far for someone who requires expensive equipment to counteract a disability, than it would for someone who lacked this disability.) Cohen (1989) defends access to advantage, while Arneson (1989) defends opportunity for welfare, as the appropriate currency of egalitarian justice.

achievement as one which was just in an egalitarian sense. Nor is it much more plausible to claim that health is the most important good that a just society should be aiming at. For this would seem to turn our commitment to health into a 'bottomless pit', as there will always be further interventions we could make which would marginally improve health, which would have to be bought at the cost of our commitment to goods other than health¹¹ (Dworkin, 2000: 309).

It follows that egalitarian justice must care about more than merely health. There are two major options. Either there is a single currency of egalitarian justice, and this currency is not health (and so health is important from the perspective of justice only for the impact that it has on this currency), or there are multiple (and mutually irreducible) currencies of egalitarian justice, and health is but one of them.¹² In this section, I shall examine three well worked out versions of these options. First, Dworkin's monistic approach, which takes there to be a single currency of egalitarian justice, which is not health. Second, the pluralistic capabilities approach of Nussbaum and Sen, according to which the capability to live a healthy life of a normal length is one of the currencies of justice. And lastly, I will look at Daniels' approach, which aims to argue that while health is not itself a currency of egalitarian justice, it is so closely related to something that is a currency of egalitarian justice (namely opportunity), that we ought to treat health as special from the perspective of justice.

Before getting to this, we must briefly address two issues. First, health is a good which is much more difficult to redistribute than others we are usually concerned about from the perspective of justice. Second, there is a question about *which* health inequalities we should be focusing on: only those which arise between different socio-economic groups, or also those which arise between individuals considered separately?

Distributing health

Most of the goods we might be concerned about from the perspective of justice are divisible and redistributable, and so it is easily possible to remove some of them from those who have too much, and bestow more on those who have too little. For instance, if we want to combat an unjust income inequality, we can quite easily redistribute money from the rich to the poor, by taxing the rich and then giving the resulting money to the poor. Or if we find that there is an unjust distribution of liberty (as, for example, in a society which allowed men, but not women to own property), we could change the law so that both men and women would equally have the liberty to own property.

However, if we were to uncover an unjust distribution of health, it would be rather more difficult to address it by redistribution, as health is not (in general) directly transferable

¹¹ The World Health Organization (WHO) definition of health, namely that health is 'is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' makes it less implausible to think that health so defined could be the most important good for a just society to focus on. However this is due to the fact the definition of health is simply too all-encompassing to be useful as a definition of *health*. (For the debate on the WHO definition of health, see further Callahan [1973] and Bok [2004]).

¹² There is also a third possibility, which I shall set aside: it might be the case that there are multiple currencies of egalitarian justice, and that health is not one of them. From the perspective of our interest in health inequalities, this would be normatively little different from the first option: in both cases health would be only indirectly relevant to justice.

from one person to another.¹³ So we can only rectify unjust distributions of health indirectly. One such way would be to ensure a just distribution of the social determinants of health. While ensuring a just distribution of the social determinants of health would clearly help to produce a just distribution of health, it would not fully rectify any current injustice, given that many of the ill health conditions which are caused by an unjust distribution of the social determinants of health will not be reversible. For example if someone has atherosclerosis as a result of working for a long time in a stressful environment in which they experienced little control over what they were doing, then allowing them decent working conditions would not undo their atherosclerosis.¹⁴ Another way of counteracting the effects of unfairly poor health would be by compensating those people with unfairly poor health with a different and more readily redistributable good (such as money, free health care or free mobility equipment). However, it is far from clear that ill health can be fully compensated by being provided with other goods (see 'Deciding between these approaches', below).

The upshot seems to be that even if we do think that health is an appropriate currency of egalitarian justice, it will not be easy, and may in fact be impossible, to bring it about that there is an equitable distribution of health.

Individual and group inequalities in health

Until fairly recently, researchers who have been interested in health inequities have assumed that the relevant inequities that we should be worrying about are inequities between groups rather than individuals, so that they have thought it was a cause for concern if certain groups (such as African Americans) do worse than other groups (such as white Americans). However, Murray *et al.* (1999, 2000) argue that we should also be interested in inequalities in health between individuals. Unless we do so, they argue, we fail to attend to the inequalities *within* these groups, and thus 'mask part of the inequality present in the population' (Murray *et al.*, 1999: 537).

It seems to me that it is only if we are committed to the view that health is a fundamental currency of justice and we think that inequalities with natural as opposed to social causes can be unjust that we ought to be concerned about individual health inequality. (If these conditions held, it would follow that each individual was owed a fair share of health. It would then simply be false to say to an individual that we had treated him justly with respect to health because the social class or race of which he was a member was sufficiently healthy.)

However, if we do not think that health is a currency of justice, we will find it much more useful to know for social policy purposes the kinds of questions that social scientific researchers have tended to concentrate on, namely how inequalities in health correlate with other variables, such as social class that *are* of fundamental concern for justice. Knowing about individual inequalities in health will not tell us very much about what we would need

¹³ Unless, that is, we redistribute healthy organs from one person to another person with less healthy organs. However this would be such a gross violation of the self-ownership of the people from whom the organs were taken that it can be safely set aside as a solution to how to distribute health justly (Segall, 2007: 358).

¹⁴ In addition, as we saw earlier, arguably there are some unjust distributions of health which do not have a social cause, so these would remain untouched by addressing the social determinants of ill health.

to do to make society more just, given that justice will depend on the distribution of goods other than health (Hausman *et al.*, 2002; Hausman, 2007). In addition, measurements of individual health inequalities do not allow us to filter out what is caused by social factors from what is caused by natural factors, and so they will be a useful measure only if there is no normative difference between these two types of health inequalities (Asada and Hedemann, 2002).

Monistic approaches

Any view of justice that takes there to be a single currency of justice will be forced to conclude that this single fundamental currency is not health. So all monistic approaches to justice present a standing challenge to the normative significance of health inequalities. We shall take Dworkin's (1981a, 1981b) account as an example of a monistic approach to egalitarian justice. Dworkin picks out resources as the currency of egalitarian justice. He uses the concept of resources in a broad way to include not just 'external' resources such as land and money, but also talents, which are theorized as 'internal' resources. Disability and ill health are understood as negative internal resources.¹⁵

Dworkin's view has two main implications for the study of health inequities. First, our duty would be to ensure a *fair share of resources* for each person. Health is only one such resource, and can reasonably be traded against other goods. So the fair distribution of resources would not require us to take health to be a special case, and to seek to equalize it separately from other goods.

Second, in Dworkin's view (in common with other luck egalitarians) the distinction between the natural and social is not of normative significance, and so should not be presupposed in a theory of justice. What matters according to Dworkin is whether someone can fairly be held responsible for the shortfall in their combined bundle of internal and external resources. If a person suffers a shortfall for which they cannot be held responsible, then this requires rectification, regardless of whether the cause of the shortfall is natural or social. So, for example, on Dworkin's view, the natural inequality in life expectancies between women and men would raise a *prima facie* case for rectification.¹⁶

In addition, Dworkin (along with other luck egalitarians) does not think that justice requires us to equalize advantages or disadvantages which result from choices that competent adults make. Hence on Dworkin's account disadvantages in terms of health or other resources caused to individuals by their competent choices to drink heavily or to not take

¹⁵ Dworkin (1981b: 312) denies that ill health and disability give someone a *direct* claim to equalization of resources, on the ground that this would amount to a 'slavery of the talented', and he argues that justice requires only that each person be given sufficient resources to enable them to purchase insurance against ill health and disability. However, it is questionable whether Dworkin's argument for this claim is consistent with his broader position, as Cohen-Christofiadis (2004) argues. For a good overview of the debate on egalitarianism and disability, see Wolff (2008).

¹⁶ There are two reasons why Dworkin would be unlikely to suggest that we take steps to remedy this gender based health inequality. First, his theory requires us to equalize resources, not health. The natural inequality in life expectancies *favours* women, and so if anything will help to counteract the gender imbalance of resources which is likely to result in a male dominated society. Second, it is difficult to see how we could systematically favour one sex over another in the distribution of health care related resources, without violating the core idea of egalitarian justice, namely that each should be entitled to treatment as an equal (Sen, 2004: 24).

exercise do not call for rectification. This would mean that we would need to work out to what extent (if any) individuals can fairly be held responsible for the types of health disadvantage which are correlated with, for example low SES.¹⁷

Capabilities approaches

Capabilities theorists, of whom Sen (1999, 2004) and Nussbaum (2000) are the preeminent exponents, differ in two fundamental ways from Dworkin. First, they believe that resources are the wrong distributive space to be working in. They argue that what is of value is people being able to function in various characteristically human ways, such as using their practical reason, or playing, or living a healthy life of an ordinary length, rather than the amount of resources at their disposal. Capabilities theorists argue it would be a mistake for a society to attempt to *provide* everyone with the given functioning, as someone may legitimately choose not to exercise it. (For example, someone may wish to fast for religious reasons, and at such a time it would be wrong for a society to force them to have the functioning of being well nourished.) So capabilities theorists argue that we should focus on providing each person with the *capability* to function in the valued way, not ensure that they do actually function in this way.

Second, they argue that we should be pluralists when it comes to justice: there are a plurality of capabilities which are jointly necessary for a flourishing human life, and we cannot fully compensate a shortfall in one capability with a superfluity of another. Given this broad pluralistic framework, the argument for why health is a functioning that matters fundamentally for egalitarian justice is simple. In Sen's (2004: 23) words:

... health is among the most important conditions of human life and critically significant constituent of human capabilities which we have reason to value. Any conception of social justice that accepts the need for a fair distribution as well as efficient formation of human capabilities cannot ignore the role of health in human life and the opportunities that persons respectively have to achieve good health – free from escapable illness, avoidable afflictions and premature mortality.

Approaches inspired by Rawls

Rawls (1971, 2005) argues that there are two principles of justice which determine the justice of the basic structure of society. First, and foremost, the liberty principle, which states that each individual has an equal right to protection by a fully adequate scheme of basic liberties. Second, a two-part principle governing which social and economic inequalities are acceptable, namely that such inequalities must first be open to all under conditions of fair equality of opportunity (the opportunity principle), and second the resulting advantages must be to the advantage of the least advantaged members of society (the difference principle).

As we have already mentioned, Rawls does not theorize a place for health in his theory of justice. There are at least three ways that we might account for health within the broad context of Rawls' theory of justice. First, we could do what Peter (2001) does, and argue that

¹⁷ Solving the problem of how to determine which actions people can reasonably be held responsible for is a difficult problem for the luck egalitarian. For an interesting (though controversial) approach to solving it, see Roemer (1993). For further discussion of personal responsibility and health inequities, see Wikler (2004).

Rawls' theory of justice is already adequate as it stands, and that we should understand health inequities to be those inequalities in health which are the result of unjust social arrangements.¹⁸ Second, we could conceive of health as a primary good, to be distributed (insofar as this is possible) according to the difference principle.¹⁹

Third, we could do what Daniels (1985, 2008; Daniels *et al.*, 2004) does, and account for health by reference to the opportunity principle. Daniels argues that we should greatly extend the opportunity principle so that it is not simply a matter of getting a fair opportunity to compete for jobs and offices (as in Rawls' vision), but rather becomes a matter of guaranteeing to each individual a fair share of the normal range of opportunities for someone with their talents. Health (argues Daniels) is a necessary condition for someone being able to access the normal opportunity range for their talents, and so a commitment to fair equality of opportunity commits us to treating health (and health care) as 'special'. Treating health and health care as special amounts to focusing on these as goods to be equalized on their own quite apart from our more general commitments to egalitarian distribution.

Deciding between these approaches

Daniels' approach claims an impressive pedigree; Rawls' theory of justice is by general consensus the best worked out and most comprehensive theory of justice that we currently have, and so to provide an account of justice and health which dovetailed neatly with Rawls would be very desirable.

However, there are two problems which Daniels' account struggles to overcome. First, it is far from clear that the importance of health and health care are correctly explained in terms of their impact on opportunity (Segall, 2007). Second, Daniels' account appears to be internally inconsistent. Daniels' argument for the specialness of health depends on the claim that health is a condition for the possibility of a normal opportunity range, whereas other goods (such as wealth) implicitly are not. He then draws the conclusion from this that whereas other goods can be distributed according to the difference principle, or even according to the free market, health and health care must be governed by the more stringent opportunity principle. However, the literature on the social determinants of health which we reviewed above shows that health is pervasively determined by the distribution of other goods, such as workplace culture, levels of income equality, the amount of social capital in a society. Hence it follows that someone's share of the normal opportunity range is significantly determined by the distribution of these other goods. And given that health

¹⁸ Peter describes this as an 'indirect' account of health inequity. It threatens to share the same problem we saw with Kawachi *et al.*'s (2002)'s definition of a health inequity, namely that it becomes unclear why we should treat the health inequalities which result from unjust social arrangements as *health* inequities. Peter (2001: 164) acknowledges this and adds that 'an indirect approach will need some justification for why health is considered a relevant indicator and such a justification will draw upon the good of health', but does nothing further to explain how we should relate this conception of the good of health to a Rawlsian approach to justice. It is unclear how she can ultimately avoid a commitment to either a position analogous to Dworkin's (which says that health matters only for the influence it has on other factors which are directly relevant to justice), or a position analogous to the capabilities approach (which makes health one of the currencies of justice).

¹⁹ This seems to be Veatch's (1999) position.

does not have the asymmetrical causal role that his argument requires, ‘we cannot argue from it for the view that health makes special demands of justice because it has an asymmetrically fundamental causal role in as a condition of opportunity for other goods’ (Hurley, 2007: 328).

This, as I see it leaves Daniels with a dilemma. Either he can expand his account of what he takes to be special, so that all the social determinants of health now count as special too because of their impact on opportunity (but, this would have results which are unattractive for egalitarianism in general²⁰) or, he could drop his claim that health is special – but this would be to give up the essence of his position on health and justice.²¹

It is more difficult to determine whether a monistic account such as Dworkin’s or a pluralistic account such as Sen or Nussbaum’s provides the best way of accounting for the place of health in a theory of justice. Ideally, we would want a theory of egalitarian justice that was both fully sensitive to all those feature(s) that make us equals, and all those goods that need to be distributed fairly if a society is to be a just one (call this the accuracy requirement), and enabled us to make useful comparative judgements about which of two situations departs more fully from what justice requires (call this the indexing requirement). The main problem is that the accuracy and the indexing requirements conflict. The indexing requirement will tend to push us towards a monistic currency of justice. This is because, ‘if two goods, or two forms of advantage and disadvantage, cannot be compared, then they cannot be placed on a common scale, and so it will become impossible, in many cases, to say whether one person is worse off or better off than another’ (Wolff and de-Shalit, 2007: 23). And clearly this problem will only get worse as we increase the plurality of incommensurable goods which we allow as currencies of justice.

However, the accuracy requirement will tend to push us towards acknowledging a plurality of goods, none of which is fully reducible to the others. Wolff and de-Shalit point out that if some form of monism about justice were true (for the sake of convenience, assume that the sole currency of justice was resources in Dworkin’s sense), it would follow that *any* disadvantage relevant to justice could be fully rectified by providing a suitable amount of this one currency. However, this seems not to be the case, particularly if the disadvantage to be suffered is an increased risk of early death, or chronic ill health. And so we seem forced by a concern for accuracy to admit that there are multiple goods which are of relevance to justice (Wolff and de-Shalit, 2007: 21–35).

This, I take it leaves us with a very difficult problem to solve in normative political philosophy. I would (tentatively) suggest that we should favour accuracy over indexing here, as there seems little point in starting our accounts of justice from a theory of value we already know to be inadequate. Although the indexing problem for a plurality of different goods looks to be very difficult to solve, it is plausible to hope that we may be able to make

²⁰ As Segall (2007: 360) explains, the claim that health is special ‘mandates that entitlement to health care should not be curtailed due to inferior or superior wealth. . . . But while this feature (“working both ways”) appears attractive when it comes to medical care, it appears considerably less attractive with regard to the other social determinants of health. Egalitarians typically do want to allocate more (social bases of) self-respect to those who have less of other goods (for example income, looks) and conversely, allocate more income to those who have smaller bundles (compared to others) of other social (and natural) assets. But treating the social determinants of health as special prohibits this.’

²¹ I examine Daniels’ position in greater depth in Wilson (2009).

some progress on it in the future.²² And if we *do* allow that there is a plurality of goods which should count as currencies of egalitarian justice, then it seems overwhelmingly plausible that health should be one, given both its importance for human life in its own right, and its status as a precondition for many other important functionings.

The how of health equity

Egalitarian justice in the broad sense has its basis in the idea that we should treat persons as equals. Even leaving aside disputes about *which* goods should count as currencies of justice, there are different interpretations of how egalitarians in this broad sense should aim to distribute those goods that are agreed to be currencies of justice. There are three main positions developed in the literature: strict egalitarianism, which argues that distributive equality is an end in itself; prioritarianism, which argues that we should give priority in the distribution of goods to those who are worst off; and sufficientarianism, which argues that justice requires only that we ensure that each person has a sufficient quantity of the thing being distributed.²³

Strict egalitarianism

Strict egalitarians believe that the best distribution of those goods that are currencies of justice is an equal one, and that there is a value to equal distributions in and of itself, even where no individual is made better off by such distributions. If we cared only about equality in health, then we would prefer a society in which there was very little inequality in health, but where life expectancies were lower, to one in which everyone lived longer, but there was much greater inequality in health. For the purposes of simplicity, let us say that we have a choice of two societies: in society A, everyone (rich or poor) dies at the age of 60, while in society B, all the poor die at 65, while all the rich die at 90.²⁴ Strict egalitarians argue that, insofar as we are egalitarians, we should favour society A to society B, as it has a more equal distribution of health.

However, while it is certainly true that society A has a more equal distribution of health, it is far from clear that we should choose it over society B, given that moving from society B to society A would be levelling down. No one is better off in society A than they are in society B, as both the poor and the rich have a higher life expectancy in society B. And in fact society A makes both rich and poor *worse off* than they would otherwise be. Many take this to be a strong intuitive complaint against strict egalitarianism.

Strict egalitarians (such as Temkin, 1993) make two moves to attempt to ward off the levelling down objection. First, they argue that equality is only *one* of the values which we should deploy when deciding how goods should be distributed all things considered. So while society A may be better from the perspective of equality, there may nonetheless be

²² Wolff and de-Shalit (2007: 89–107) propose a practical strategy for solving indexing problems in real world solutions, which looks like a promising avenue for further research.

²³ In this section I shall assume that health is a currency of justice in the relevant sense. I do not take it that this has been established by the argument in the previous section. I make this assumption simply because, unless health is a basic currency of justice, there will be little further to be said about how we should go about distributing health justly.

²⁴ For the purposes of simplicity I am making the rather unrealistic assumption that there are no individual health variations *within* the groups.

compelling reasons to favour society B, all things considered. Second, they argue that the levelling down objection presupposes a person-affecting requirement, namely that one situation cannot be better than another unless there is a person for whom it is better; however this requirement is false.

The strict egalitarian's first response may well appear to be dodging the issue: what we are attempting to work out is the overall principle or principles by which to distribute those goods which are the currencies of justice. To be told that strict egalitarianism is but one principle that needs to be weighed against as yet to be specified others, is not perhaps as helpful as one would have liked.

The problem with the strict egalitarian's second reply is that, as Hurley (2007) points out, it is not true that all objections to levelling down presuppose the person-affecting requirement. So even if the person-affecting requirement were false, it would not follow that levelling down in health is acceptable. If a good which is a currency of justice is not only good for the person who has it, but is also impersonally good, then there would be reasons to object to levelling down in respect of that good that are separate from the person affecting requirement. Hurley (2007: 332–3) argues that health is just such a good:

Health is a distinctive type of flourishing, with a specific natural character and basis . . . It is not just good for people to be healthy rather than unhealthy; it is also good in itself for there to be healthy people rather than unhealthy people.

If this is true, then there is an intuitively obvious objection to levelling down in health which does not rely on the person affecting principle, namely that 'leveling down wastefully throws away the higher reaches of good' (2007: 332). And so the objection to levelling down seems to stand, at least when we are distributing health.

Prioritarianism

Thinking about the problem of levelling down has led many to the view that the core commitments of egalitarian justice in health should not be strict egalitarianism, but rather to what has come to be known as *prioritarianism*, namely that we should give priority to improving the condition of those who are worst off (Parfit, 1997). Rawls' difference principle is an explicitly prioritarian principle of justice, namely that social and economic inequalities are to be to the greatest benefit of the least advantaged members of society.

Prioritarianism is very appealing as an account of what we owe to one another when it comes to health. However, while it may be true in most obvious cases that we should give priority to alleviating the condition of the worst off, giving an *absolute* priority to improving the condition of the worst off can have counterintuitive implications. For it may well be the case that it is much less cost effective to attempt to improve the condition of those who are the very worst off, than to attempt to improve the conditions of some other groups who are slightly better off. (This is often the case in health care, where those who are worst off frequently require very expensive treatments which only succeed [if at all] in improving their condition marginally.) And so a focus on giving priority to the worst off will sometimes conflict with considerations of cost-effectiveness and efficiency.²⁵

²⁵ The underlying worry here is similar to the levelling down objection. But where the levelling down objection concerns cases where *no one* gains and there is a significant loss to some, this objection concerns cases where there is a slight benefit to some, but a much more significant loss to others.

Prioritarians can address this challenge from efficiency in one of two ways: either they can deny that considerations of efficiency have any role to play here, and claim that even if *much more* good could be done to those who are less badly off, we should still focus our efforts on those who are worst off. Or they can shift to a position which has come to be known as *weighted prioritarianism*, which claims that priority to the worst off is to be given a high (but not absolute) weighting, so that in certain circumstances priority to the worst off can legitimately be overridden by the demands of efficiency.

Sufficientarianism

Sufficientarians (Frankfurt, 1987; Crisp, 2003a, 2003b) argue that priority is only to be given to those who are worse off than a certain threshold, and that if everyone is above this threshold, benefits to those who are comparatively better off count equally to those who are comparatively worse off. The policy implications of a sufficientarian approach to health would clearly depend on what we took the relevant threshold to be for health achievement. If the threshold was set high (for instance to 90 years of healthy life), then a sufficientarian approach would not be distinguishable in practice from a prioritarian approach. However, if the threshold was set low (for instance, to 50 years of moderately healthy life), then socio-economic conditions which caused someone to die at 55 or 60 would not deprive someone of a share of healthy life to which they were entitled by justice.

Crisp (2003a, 2003b) argues that we should set the level of sufficiency through the exercise of compassion from the perspective of an impartial observer. However, this seems not to be a very complete answer, given that what we reasonably feel compassion for is closely related to what we feel is to be expected. And indeed, it is hard to see how there could be a nonarbitrary way of deciding how long a life was 'long enough'. As Hooker (2008: 190) puts it, 'As long as a pleasant, intellectually active, socially interactive life is possible, I cannot see why anyone's "needs" expire at 70 years, or at 100 years, or at 150 years.' So it may be that when we are thinking about the length of life, there is no relevant sufficiency threshold. It is more plausible to think that there could be an objective standard for when a life of a given length is sufficiently healthy. But even here we would face the very difficult task of deciding what that level should be, a problem the prioritarian (who only needs to determine who is worse off) does not face.²⁶

I take it that these difficulties give us some reason to favour prioritarianism over sufficientarianism when we are distributing health, even if only on pragmatic grounds.

Conclusion

Social scientists working on health inequalities have often thought that it is simple to identify health inequities. For example, Dahlgren and Whitehead (2006: 3) forthrightly state that:

In today's Europe, working out what social differences in health are fair and unfair is unnecessary. Essentially, all systematic differences in health between different socioeconomic groups within a country can be considered unfair and, therefore, classed as health inequities. There is no biological

²⁶ As Hooker (2008) reminds us, 'All prioritarianism has to do is determine who is worse off, and this seems much easier than determining whether y 's getting x is something that y needs or merely something that would benefit y . . . Crisp needs to defend a line; prioritarianism has no line to defend.'

reason for their existence, and it is clear that even systematic differences in lifestyles between socioeconomic groups are to a large extent shaped by structural factors.

This chapter has argued that things are rather less clear cut than this, and that it is a much more complex matter to determine which inequalities in health should count as inequities. Which inequalities in health should count as inequities is, we argued, on analysis a matter of which inequalities in health are unjust.

We saw that there are two different dimensions to theories of egalitarian justice. First, there is the question of which goods we should take to be the currencies of justice. Here we argued that, despite the indexing problems it causes, there is reason to favour a pluralistic account of the currencies of justice over a monistic account, and that if we adopt a pluralistic theory of justice it is overwhelmingly plausible to think that health should be one of the currencies. Second, there is the question of how we ought to distribute those goods that are currencies of justice. Here we suggested that when we are distributing health, an approach that gives priority to those who are worst off may be preferable both to a strict egalitarian one, and a sufficientarian one.

Assuming this is correct, it follows that justice requires us above all to concentrate on improving the condition of the worst off, and that what makes one person worse off than another will be, among other things, their health state. Flattening socio-economic gradients in health will be one important way of improving the condition of those who are worst off, especially as so doing will also require us to distribute goods other than health more equitably.

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