Rawlsian Justice and the Social Determinants of Health

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Abstract

In this paper, we suggest that the evidence regarding the social determinants of health calls for a deep re-thinking of our understanding of distributive justice. Focusing on John Rawls’s theory of distributive justice in particular, we argue that a full reckoning with the social determinants of health requires a re-working of Rawls’s principles of justice. We argue first that the social bases of health – a Rawlsian conception of the social determinants of health – should be considered a social primary good. We argue second that including the social bases of health as a social primary good would lead the parties to the original position to choose an additional principle of justice and assign it lexical priority over Rawls’s second principle. According to this principle, inequalities in people’s share of the social bases of health are to be arranged so as to improve the health status of those least advantaged on the social health gradient.

Text

From 2001 to 2014, American men in the bottom 1% of the income distribution could expect to live 14.6 years less than American men in the top 1% of the income distribution, with life expectancy increasing continually with income.1 In a recent survey, 38.2% of U.S. respondents in the bottom third of the income distribution reported fair or poor health, compared to 21.4% of respondents in the middle third, and 12.3% of respondents in the top third, disparities unaffected by adjustment for health insurance status.2 These findings are part of a larger body of research that has consistently found a social gradient in health within low-, middle-, and high-income societies: the lower people’s socioeconomic position, the worse their health status even in countries with universal access to health care.3 To explain these health disparities, epidemiologists have concluded that there are *social determinants of health*, that is, socially controllable factors – excluding the traditional health care system – that are independent partial causes of an individual's health status.4

Many of the proposed social determinants of health, including income, education, and occupational rank, are also the focus of influential theories of distributive justice. It would be convenient if such theories, often developed without consideration of the social determinants of health, required no fundamental rethinking to accommodate them. Norman Daniels argues that this is the case with John Rawls’s theory of distributive justice, justice as fairness. While Daniels reinterprets Rawls’s principle of fair equality of opportunity to justify the provision of health care to people,5 Daniels argues that with respect to the social determinants of health, neither Rawls’s framework nor his two principles require any modification. Instead, he claims that “social justice, as described by Rawls’s principles, is good for our health and promotes its fair distribution.”6 Daniels acknowledges that full compliance with Rawls’s two principles may still imply inequalities in health status; but argues on pragmatic grounds that such “residual inequalities that emerge with conformance to the principles…are acceptable as just.”7

In this paper, we suggest that the evidence regarding the social determinants of health calls for a deep re-thinking of our understanding of distributive justice. Focusing on Rawls’s theory in particular, we argue that a full reckoning with the social determinants of health requires a *re-working* of Rawls’s principles of justice. We argue first that the *social bases of health* – a Rawlsian conception of the social determinants of health – should be considered a social primary good. We argue second that including the social bases of health as a social primary good would lead the parties to the original position to choose an *additional* principle of justice, and assign it lexical priority over Rawls’s second principle:

Inequalities in people’s share of the social bases of health are to be arranged so as to improve the health status of those least advantaged on the social health gradient.

This rethinking of Daniels’s approach is necessary, we suggest, to avoid problems critics have identified with Daniels’s approach. Gopal Sreenivasan argues that Daniels’s position fails to address the fundamental question of whether the residual health inequalities he acknowledges are just qua health inequalities.8 As we argue below, such residual health inequalities may be sizeable in certain circumstances, and so Daniels needs to provide some normative – rather than merely pragmatic – reason to think they are just.9 Call this the problem of *incompleteness*.

Critics also argue that Daniels’s position on the justice of residual health inequalities is inconsistent with other features of his account. Since Daniels’s principle of fair equality of opportunity implies that health inequalities that diminish people’s share of the normal opportunity range are unjust, these critics argue, it is puzzling why his position does not also imply that residual health inequalities are also unjust insofar as they too diminish people’s share of this range.10 Call this the problem of *inconsistency*.

Our aim in this paper is develop a Rawlsian account of the just distribution of the social determinants of health that is subject to neither of these problems. We do not aspire to develop a comprehensive account of health justice, for example, one that addresses all questions regarding public health policy and health insurance. However, given the significant impact of the social determinants of health on health outcomes, the project of developing a satisfying Rawlsian account of their just distribution is an important one.11

In part 1, we introduce the idea of the social bases of health as a social primary good, relying on the *social bases of self-respect* as a model. In part 2, we argue that the parties to the original position would choose the above-mentioned principle of justice to govern the distribution of this good. In part 3, we respond to an objection.

1 The Social Bases of Health

We are not the first scholars to propose that the social bases of health should be considered a social primary good. In an article criticizing Daniels’s account, James Wilson suggests that if Daniels wishes to make good on his claim that health is special, he “could introduce the social bases of health as an additional Rawlsian primary good.”12 Wilson continues, “Whilst Rawls seems never to have revised his views to take into account the social determinants of health, and promote health to the status of a primary good, this would be an obvious option for anyone thinking about health and justice now.”13 In this part of the paper, we develop Wilson’s proposal in a systematic fashion.

1.1 Primary Goods

In *A Theory of Justice*, Rawls claims that primary goods are those “things that every rational man is presumed to want.”14 In later work, Rawls specifies that the idea of primary goods depends on a conception of the person that is “fundamental to justice as fairness.”15 According to this conception, persons are understood to have two moral powers. First, they have a capacity for a conception of the good, that is, a capacity to set, revise, and pursue a rational plan of life.16 Second, they have a capacity for a sense of justice, that is, a capacity to propose and comply with fair terms of social cooperation.17 In addition to possessing these two moral powers, persons have *highest-order interests* in developing and exercising these powers, and a *higher-order* interest in pursuing their determinate conception of the good.18

This conception of the person informs the structure of the original position.19 The nature of the parties models persons’ capacity for a conception of the good and their corresponding highest-order and higher-order interests concerning this power; the veil of ignorance and the symmetrical situation of the parties models persons’ capacity for a sense of justice.20 More importantly for our purposes, the capacity for a conception of the good provides the basis for Rawls’s idea of primary goods. Primary goods, Rawls claims, are those goods and background conditions persons require if they are to realize their highest-order interest in developing and exercising their capacity for a conception of the good and pursue their determinate conception of the good.21

There are two types of primary goods. *Natural* primary goods are those goods that while necessary for the realization of persons’ highest-order interests and also “influenced by the basic structure,” are not “so directly under its control.”22 Natural primary goods, Rawls claims, therefore include intelligence and imagination, but also health and vigor.23 *Social* primary goods, by contrast, are those goods and conditions that are directly under the control of the basic structure. As such, social primary goods are “certain features of institutions or of the situation of citizens in relation to them,” making the determination of each citizens’ possession of socially primary goods an “in principle publicly decidable matter.”24 They include:

1. Basic rights and liberties;
2. Freedom of movement and freedom of occupation;
3. The powers and prerogatives of offices and positions of responsibility;
4. Income and wealth; and
5. The social bases of self-respect.25

Rawls’s claim that health is a natural primary good would seem to imply that principles of social justice should not govern its distribution. However, we suggest next that the social bases of self-respect provide a model for integrating health into Rawls’s theory at the foundational level.

1.2 From the Social Bases of Self-Respect to the Social Bases of Health

In discussions of Rawls’s theory of justice, commentators often ignore the social bases of self-respect. Indeed, Rawls’s two principles of justice, while clearly governing the distribution of the first four social primary goods, do not seem to mention or concern the fifth. This is striking since Rawls claims that it is “perhaps the most important primary good” since without it, “nothing may seem worth doing.”26 The parties to the original position, Rawls claims, would therefore “wish to avoid at almost any cost the social conditions that undermine self-respect.”27

Self-respect, according to Rawls, has two components. First, it includes a person’s sense of their own value as a person, as well as the secure belief that their plan of life is worth carrying out.28 Second, it includes a person’s confidence in their ability to carry out their plan of life, to the extent that doing so is within their power.29 Noting that the first component seems to include two components, Richard Penny helpfully suggests that Rawls’s conception of self-respect involves: (1) a sense of self-worth, (2) a sense of plan-worth, and (3) a sense of self-confidence.30

While self-respect is clearly a primary good, Rawls does not claim it is a *social* primary good.31 Rawls’s reasoning is that whether a person possesses self-respect, while influenced by the basic structure, is not under its direct control.32 What is under the direct control of the basic structure however, is the *social bases* of self-respect, those features of a society’s institutions that affect whether persons have this attitude or not. For Rawls, the central social basis of self-respect is the political constitution and the way in which it distributes basic rights and liberties. Since the first principle of justice requires that these rights and liberties be distributed equally, the social bases of self-respect are also distributed equally in a just society.33

Rawls’s discussion of the social bases of self-respect provides a model for how to integrate considerations of health into justice as fairness. Consider first that self-respect is clearly analogous to health. Like self-respect, health is: (1) necessary if people are to realize their highest-order interest in developing and exercising their capacity for a conception of the good; and (2) not under the direct control of the basic structure – i.e. influenced by a number of different factors.

Consider second that health, like self-respect, is *significantly affected* by features of the basic structure. Now, to show that self-respect is affected by the basic structure, Rawls largely engages in a priori philosophical reasoning. Following Jeffrey Moriarty however, we think that the appropriate way to determine if some feature of the basic structure significantly affects the possession of a natural primary good – and so should be considered a *social* primary good – is to appeal to empirical evidence. As Moriarty puts it:

Philosophers, including Rawls, often suppose that the social bases, or determinants, of self-respect and self-esteem can be identified through a priori reflection. This approach is appropriate for identifying the boundaries of the associated concepts. Yet it seems clear that once we know their boundaries, identifying these states’ determinants is an empirical inquiry. As seen, self-esteem is fundamentally a type of attitude that one has toward oneself. Self-respect is also a type of attitude, combined with a set of actions consistent with it. To determine whether X is a determinant of one of these states, we need empirical evidence demonstrating causation – or, minimally, correlation – between X and it. In the absence of such evidence, a priori reflection about the state’s determinants, even when intuitively plausible, can only serve as a guide for where we might focus an empirical inquiry.34

To show that the basic structure significantly affects health, there must therefore be empirical evidence showing that features of the basic structure cause, or are at least correlated with, health status.

Fortunately, this evidence exists. Research in epidemiology has identified a social gradient in health within low-, middle-, and high-income societies: the lower people’s socioeconomic position, the worse their health status even in countries with universal access to health care. Within countries therefore, people with higher socio-economic status, understood in terms of income, education, and occupational rank, tend to live longer and experience less morbidity.35 For example, the highly influential first Whitehall study found a strong correlation between employment grade and cause specific mortality amongst 18,000 male civil servants living and working in the greater London area and with access to health care provided by the National Health Service. This study followed 19,019 male civil servants, aged 40-69, from 1967 to 1995, noting their employment grade and cause of death.36 The study found higher mortality rates for civil servants with lower employment grades, including for nearly all specific causes of death, and also found that major risk factors could only explain a third of this difference.37

On the basis of the first Whitehall study and other work, epidemiologists have concluded that there are *social determinants* of health, where a social determinant of health is any “socially controllable factor outside the traditional health care system that is an independent partial cause of an individual's health status.”38 Although the concept of social determinants of health has become widely accepted, there is still disagreement about: (1) whether socio-economic status in fact *causes*, or is merely correlated with, changes in health status; and (2) which component features of socio-economic status – if any – are causal in this way.

We are not in a position to decide these questions. However, we will proceed on the basis of two assumptions: (1) social determinants of health exist – i.e. features of socio-economic status *cause* changes in health status; and (2) the social determinants of health include income, occupational rank, and education. Although these assumptions are controversial, they allow us to fully explore the potential ramifications of the social determinants of health for Rawls’s theory of justice, given that Rawls’s principles of justice govern the distribution of these goods.

Given these assumptions it follows that features of the basic structure significantly affect people’s health status. After all, the basic structure includes those laws and policies determining the distribution of income, educational opportunities, and occupational rank among other factors. Health is thus analogous to self-respect in this regard, and so the same reasons for classifying the social bases of self-respect as a social primary good imply that we need some analogous social primary good for health. We call this social primary good the *social bases of health*.

Social Bases of Health: Those aspects of the basic structure that are a partial, independent, and positive contributor to people’s health status.

We use social *bases*, not social *determinants*, to indicate that there are important differences between the social bases of health and the social determinants of health. First, for Rawls, social primary goods are goods whose distribution is strongly influenced by the basic structure. The concept of social determinants of health, by contrast, refers to the idea of social controllability, a concept that is broader than the concept of the basic structure. In particular, scholars have recently argued that the social determinants of health should be understood to comprise both “structural determinants” of health and “intermediary determinants of health.”39 The former refers to those structural features of the socio-economic and political context that define people’s socioeconomic position, for example, public policies that influence people’s income, education, and occupation.40 The latter refers to downstream processes through which the structural determinants work to result in health inequalities, including the material circumstances of people’s lives – e.g. housing quality – and behavioral factors – e.g. diet and levels of exercise.41 Our notion of the social bases of health, given its focus on the basic structure, is roughly equivalent to the concept of the *structural* determinants of health, a narrower concept than the *social* determinants of health.

Second, social primary goods are *goods*, that is, things that it is rational for persons to want more of. The social determinants of health, by contrast are not goods per se since they refer to factors that contribute positively *and* negatively to people’s health status. Since the social bases of health are *goods*, we shall understand them to be those features of the basic structure that contribute positively to people’s health status.

We stipulate that the social bases of health are distributed equally when the relevant aspects of the basic structure are arranged so as to have an equal positive effect on people’s health status. One person therefore has a greater share of the social bases of health if the relevant aspects of the basic structure are arranged to have a greater positive effect on their health status than on the health status of another. In societies in which there is a social gradient of health, those with higher socio-economic status have a greater share of the social bases of health than those with lower socio-economic status. To capture the idea that features of the basic structure can also contribute *negatively* to people’s health status, we suggest that it is possible for people to have a negative share of the social bases of health, much in the same way that people with greater debt than assets have negative wealth.

Daniels considers the possibility of reclassifying health as a social primary good in light of evidence regarding the social determinants of health. Speaking of Rawls’s distinction between natural and social primary goods, he writes that recent work in epidemiology “undermines much of the force of this contrast” and that in “whatever sense health is a natural good, its distribution is to a large extent socially determined.”42 However, he decides against reclassifying health as a social primary good, arguing first that doing so risks “generating a long list of such goods” which may include goods that are not necessary to citizens considered as free and equal persons.43 He argues second that adding health to the index of social primary goods makes the indexing problem even more complex, requiring legislators to make tradeoffs amongst health, income and wealth, and the powers and prerogatives of office.44

We think these are weak reasons to resist the introduction of the social bases of health as a social primary good. First, we are only proposing the addition of one good, and, as we argue above, this good is central to people’s ability to develop and exercise their two moral powers. As Wilson puts it, it is simply not contentious to claim that health is important to citizens qua free and equal persons.45 Second, while adding the social bases of health may make the indexing problem worse, given the importance of health to free and equal persons, it is better to make the problem worse and so recognize – rather than ignore – the tradeoffs that must be made. Moreover, as Rawls notes, the indexing problem only arises for goods distributed by the difference principle, and we argue below that the social bases of health should not be governed by it.46

2 Justice as Fairness and the Social Bases of Health

Our claim that the social bases of health is a social primary good implies that the parties to the original position face a different decision: they must now choose principles of justice to govern the distribution of six, not five, social primary goods:

1. Basic rights and liberties;
2. Freedom of movement and freedom of occupation;
3. The powers and prerogatives of offices and positions of responsibility;
4. Income and wealth;
5. The social bases of self-respect; and
6. The social bases of health.

We argue first that the parties to the original position would choose an *additional* principle of justice to govern the distribution of the social bases of health and give it lexical priority over Rawls’s second principle of justice. We then discuss the implications of this reworking of Rawls’s principles of justice for the evaluation of social and economic policy. We would note that the arguments we introduce below are independent of the arguments we introduce above. Even if one does not accept our arguments regarding the principles of justice to govern the distribution of this extended list of social primary goods, our claim regarding the need to include the social bases of health on this list still stands.

2.1 Revising Justice as Fairness

To determine whether and how the inclusion of the social bases of health would alter the parties’ deliberation, it is crucial to first recognize that Rawls draws two distinctions regarding the *importance* of the different social primary goods. These goods, Rawls claims, matter differently to free and equal persons concerned to realize their highest-order and higher-order interests.

Rawls argues first that the basic rights and liberties are more important to the parties than the other social primary goods since they constitute the “background institutional conditions necessary for the development and the full and informed exercise of the two moral powers.”47 As such, the basic rights and liberties play a distinctive role in enabling persons to realize their *highest-order interest* in developing and exercising these powers. Rawls’s idea here is that people can only exercise their two moral powers if they have a sphere of action in which they, not the state, are sovereign. For example, with respect to the capacity to be rational, people can only explore different religious faiths and live according to the faith of their choosing if freedom of expression and liberty of conscience are protected.48

Rawls also assigns this level of importance to freedom of movement and freedom of occupation, and the social bases of self-respect. Freedom of movement and freedom of occupation, Rawls claims, are tightly connected to and supportive of the basic rights and liberties49 and so are protected by the first principle of justice.50 The social bases of self-respect, Rawls claims, are similarly “aspects of basic institutions normally essential if citizens are…to be able to develop and exercise their moral powers.”51

These social primary goods are thus more important to the parties to the original position since they are necessary if people are to realize their highest-order interest in developing and exercising their two moral powers. By contrast, income and wealth and the powers and prerogative of offices, Rawls claims, are not necessary in this way but instead allow citizens to realize their *higher-order* interest in pursuing a determinate conception of the good.52 As Rawls puts it, “income and wealth are needed to achieve directly or indirectly a wide range of ends.”53 As such, the former social primary goods take precedence over the latter; and it is for this reason that the first principle of justice is given lexical priority over the second.54

Rawls draws a second distinction between the powers and prerogatives of offices and income and wealth, suggesting that the former is more important than the latter. Offices must be open to all, Rawls claims, not only because of their “external rewards” but also because they offer their occupants the “realization of self which comes from a skillful and devoted exercise of social duties…one of the main forms of human good.”55 For this reason restricted access to the powers and prerogatives of offices cannot be compensated for by a greater share of income and wealth.56 Consequently, fair equality of opportunity has lexical priority over the difference principle.57

With which set of social primary goods does the social bases of health belong? We think that the social bases of health are most analogous to those social primary goods that are necessary if people are to realize their highest-order interest in fully exercising their two moral powers. The reason for this is that people cannot fully exercise these powers unless they are healthy. For example, fully exercising one’s capacity for a conception of the good requires the cognitive and emotive abilities necessary to deliberate about the value of goals; and it requires the physical abilities necessary to pursue the goals one sets.58 The full exercise of this power therefore requires first that one is alive, but also second, that one’s cognitive, emotive, and physical abilities are fully functional. Since health, like self-respect, is necessary if people are to fully exercise their two moral powers, the social bases of health, like the social bases of self-respect belongs with those social primary goods that are crucial for the realization of people’s highest-order interests.

What does this imply for the parties’ choice of principles? Recall that the parties to the original position are concerned to choose principles of justice that will secure for them the highest share of social primary goods. However, because they do not know features of their identity, they have no way of choosing principles of justice that will favor them. With respect to the basic rights and liberties and freedom of movement and freedom of occupation, the parties therefore have reason to choose a principle guaranteeing an equal distribution of these social primary goods. The same reasoning would lead the parties to choose – as a baseline – a principle ensuring that the social bases of health are distributed equally, where an equal distribution of the social bases of health occurs when the relevant aspects of the basic structure are arranged so as to have an equal positive effect on people’s health status.

However, in contrast to the basic rights and liberties, it is possible that an unequal distribution of the social bases of health could be better for all. Recall from above that one person has a greater share of the social bases of health if the relevant aspects of the basic structure are arranged to have a greater positive effect on their health status than on the health status of another. If absolute income is a social basis of health, and, as Rawls argues, an unequal distribution of income may improve the income expectations of the least advantaged, then an unequal distribution of the social bases of health may improve the health status of those least advantaged on the social health gradient. Since the parties to the original position are primarily concerned to organize the basic structure in such a way that it has the greatest positive effect on people’s health status that is possible, we suggest that the parties would thus choose a principle similar in structure to the difference principle. The revised set of principles is as follows:

1. Each person has an equal claim to a fully adequate scheme of equal basic rights and liberties, which scheme is compatible with the same scheme for all; and in this scheme the equal political liberties, and only those liberties, are to be guaranteed their fair value.59
2. The social bases of health are to be arranged so as to have the greatest positive impact on the health status of those least advantaged on the social health gradient.
3. Social and economic inequalities are to satisfy two conditions: first, they are to be attached to positions and offices open to all under conditions of fair equality of opportunity; and second, they are to be to the greatest benefit of the least advantaged members of society.60

The idea underlying (2) is that it is just for governments to arrange the social bases of health in such a way that leads to unequal impacts on the health status of people, provided that those least advantaged by this arrangement – i.e. those lowest on the social health gradient – have a higher health status than they would have under an equal distribution.

With respect to the question of priority, since the social bases of health belong with the social bases of self-respect, the basic rights and liberties, and freedom of movement and freedom of occupation, the first and second principles have lexical priority over the third principle of justice. However, although the social bases of health belong with the basic rights and liberties, we also assign the first principle lexical priority over the second. To fully exercise one’s capacity for a conception of the good and so decide on a particular plan of life, after all, one must be free of paternalistic state interference, even when that interference limits one’s ability to make choices that pose risks to one’s health.61

2.2 Implications for Social and Economic Policy

Since the social determinants of health are thought to be factors constitutive of people’s socioeconomic status – i.e. income, education, and occupational rank – (2) governs the design of social and economic policy. How does our revision to justice as fairness alter our vision of a “just Rawlsian society”?

To answer this question, it is helpful to consider some of the principal candidates for the social bases of health, particularly those that are related to Rawls’s social primary goods, namely, education, occupational rank, and income. Consider education first. In a review of the literature on the social health gradient and its specific causes, David M. Cutler, Adriana Lleras-Muney, and Tom Vogl note that there is a strong correlation between education and health outcomes in the United States and a wide range of countries in Europe.62 They also note that analyses of natural experiments provide evidence that education causes better health outcomes.63 As possible explanations for this relationship, Cutler, Lleras-Muney, and Vogl suggest that better educated people may be more informed about healthy behaviors and also better equipped to access new medical technologies.64

As Cutler, Lleras-Muney, and Vogl note, there is controversy regarding whether education is a social determinant of health or merely a mediating factor.65 However, we shall proceed on the assumption that it is the former. Since our aim in this paper is to fully explore the potential ramifications of the social determinants of health for Rawls’s theory of justice, it is reasonable to be *over-inclusive* regarding possible social determinants of health, particularly where such candidates overlap with Rawls’s social primary goods. Moreover, despite scholarly disagreement, as Cutler, Lleras-Muney, and Vogl argue, there is evidence to suggest that education is a social determinant of people’s health not merely a mediating factor.66

There is also evidence that occupational rank is a social determinant of health. In the first Whitehall study, Marmot et al found that there were higher rates of mortality due to coronary heart disease among men in lower employment grades than men in higher employment grades, with only a quarter of the variation explainable by social differentials in smoking, plasma cholesterol, blood pressure, height, obesity, and physical activity.67 The Whitehall II study was designed to test the hypothesis that part of the variation could also be explained by psychosocial factors related to work. Working with data from this study, Marmot et al. found support for this hypothesis, concluding that low control in the workplace – measured in terms of the authority to make decisions and skill discretion – contributes to the incidence of coronary heart disease.68

Finally, there is evidence that income is a social determinant of health, though there is disagreement about how it matters and for whom. First, although there are strong correlations between income and health,69 it is unclear whether this is because higher incomes *cause* good health.70 After all, good health contributes to people’s ability to participate in the labor market, and higher incomes allow people to purchase better health care and more nutritious food.71 In addition, income is also correlated with education, meaning it could be education that is the causal factor explaining the correlation between income and health.72 Second, there is disagreement about whether income is a social determinant of the health status of adults, or only of children. While there is good evidence to suggest that parental income matters for the health of children,73 it is less clear that income matters for the health status of adults.74

There is also disagreement about whether it is only people’s *absolute* income that is a social determinant of health, or whether people’s *relative* income affects their health status as well, that is, that greater income inequality contributes negatively to the health status of the least advantaged.75 While some scholars argue that there is no evidence to support the claim that relative income is a social determinant of health,76 others disagree. For example, in a recent article, Richard Wilkinson and Kate Pickett consider the epidemiological evidence regarding the relationship between income inequality and various health outcomes and conclude that by the standards of epidemiological causal criteria, the evidence strongly suggests that there is a causal relationship between income inequality and life expectancy and mental health.77

Now, if the social bases of health only include education and absolute income, the addition of (2) to justice as fairness should be purely cosmetic. The reason for this is that (2) allocates the goods of income and education in the same way that (3), Rawls’s second principle of justice, allocates them. With respect to income, (2) permits inequalities in income provided these inequalities have the greatest positive impact on the health status of those least advantaged on the social health gradient. If absolute income is a social basis of health, this means that inequalities in income are permissible provided they are necessary to raise the income expectations of the least advantaged.78 With respect to education, if education is a social basis of health, (2) requires that all people have equal opportunity to acquire it. (2) is thus no different from the principle of fair equality of opportunity, a key component of (3).79

If the social bases of health include either relative income or occupational rank however, the addition of (2) may imply that a just Rawlsian society is more egalitarian than Rawls supposed. Consider relative income first. Recall that if relative income is a social basis of health, this means that greater income inequality contributes negatively to the health status of the least advantaged. (2) therefore forbids inequalities that have this effect since they would give the least advantaged a negative share of the social bases of health.

This does not mean that (2) demands that income must be distributed equally. First, it might be the case that only income disparities of a certain size contribute negatively to the health status of the least advantaged, meaning inequalities that do not reach this limit would be permissible. Second, if absolute income is also a social basis of health, and inequalities in absolute income can contribute positively to the income expectations, and therefore health status, of the least advantaged, then certain inequalities in income may be permissible even if they are great enough to contribute negatively to the health status of the least advantaged – i.e. if the positive contribution of absolute income is greater than the negative contribution of relative income inequality.

The reason that the addition of (2) may lead to a more egalitarian Rawlsian society – on the assumption that relative income is a social basis of health – is that (2) may forbid income inequalities that (3) would permit. For example, suppose that allowing certain inequalities in income would improve the income expectations of the least advantaged compared to the status quo. Suppose further however that because relative income is a social basis of health, such inequalities would lead to worse health outcomes for those least advantaged on the social health gradient. Policies enabling these inequalities in income would satisfy (3) but they would not satisfy (2). Since (2) takes lexical priority over (3), the policies in question would be unjust.

Consider occupational rank next. Occupational rank is roughly equivalent to Rawls’s conception of the powers and prerogatives of offices. The former, as we note above, refers to the degree of decisional authority employees have and the degree to which they can deploy skill and expertise in a stimulating and challenging context. Rawls’s comments on the powers and prerogatives of offices are brief. However, Samuel Arnold offers a well-considered reconstruction of Rawls’s position. According to Arnold, the powers and prerogatives of office capture job complexity, authority, and responsibility.80 Occupational *equality* obtains, on Arnold’s view, when all jobs feature similar levels of complexity, authority, and responsibility; occupational *inequality* obtains when jobs feature different levels of complexity, authority, and responsibility.81 On Arnold’s reading of Rawls therefore, the powers and prerogatives of offices are roughly equivalent to the conception of occupational rank that is considered to be a social determinant of health in the epidemiological literature.

The evidence supporting the claim that occupational rank is a social basis of health implies that it is low control in the workplace – measured in terms of the authority to make decisions and skill discretion – that contributes negatively to the health of workers. This suggests that occupational rank is structurally analogous to relative income qua social basis of health. Greater disparities in occupational rank contribute negatively to the health status of the least advantaged, and so policies that flatten workplace hierarchies, distributing decisional authority and job complexity more widely, promise to improve the health status of those least advantaged on the social health gradient.

As with relative income, this does not mean that (2) implies that inequalities in occupational rank are unjust – i.e. that workplace hierarchies must be completely eliminated. First, it may be that only disparities in occupational rank of a certain size contribute negatively to the health status of the least advantaged. Second, inequalities in occupational rank may play an important role in creating wealth and so raising the income expectations of the least advantaged. In some cases, the positive contribution to the health status of the least advantaged from an increase in income may be greater than the negative contribution from an increase in inequality in occupational rank, meaning that the latter inequality would be permissible under (2).

But the addition of (2) does imply that some inequalities in occupational rank that would satisfy (3), may be unjust. Some inequalities in occupational rank, after all, may satisfy the difference principle insofar as they imply a bundle of income and the powers and prerogatives offices that would be preferred by the least advantaged compared with the bundle promised by a more equal distribution of occupational rank.82 For example, the least advantaged may prefer a bundle of social primary goods with less powers and prerogatives of offices but greater income than a bundle with more powers and prerogatives of offices but less income. But, such inequalities in occupational rank will not satisfy (2) if they are expected to negatively contribute to the health status of the least advantaged.

If relative income and occupational rank are social bases of health therefore, under certain empirical circumstances, a just Rawlsian society would be more egalitarian with respect to the distribution of income and the powers and prerogatives of offices than Rawls supposed. Some inequalities in the distribution of these goods that satisfy (3) may not satisfy (2) since they contribute negatively to the health status of the least advantaged. Since (2) takes lexical priority over (3), such inequalities are unjust.

3 An Objection

Daniels’s Rawlsian account of the just distribution of the social determinants of health is of course not the only account on offer.83 However, since the aim of our paper is to develop a Rawlsian alternative to Daniels’s account, we consider an objection that Daniels might raise.

Daniels might argue that the basic premise of our paper is mistaken since his account can be revised to address the problems of incompleteness and inconsistency. To address these problems, he might argue, the principle of fair equality of opportunity need only be applied to the distribution of the social determinants of health. This revision addresses both problems, he might argue, since his account would now condemn residual health inequalities as unjust.

This proposal may indeed resolve the problems of inconsistency and incompleteness. However, we argue that fair equality of opportunity is the wrong principle to govern the distribution of the social determinants of health.

Consider first that Rawls’s principle of fair equality of opportunity is a *relative* principle of equality of opportunity, not an *absolute* one. For Rawls, whether one has a fair share of opportunity depends on whether one’s opportunity is equal to that of others, not whether one has sufficient opportunity as judged by some absolute standard. As Rawls puts it, “assuming that there is a distribution of natural assets, those who are at the same level of talent and ability, and have the same willingness to use them, should have the *same prospects of success* regardless of their initial place in the social system.”84

Rawls conceptualizes fair equality of opportunity in this way since this principle governs access to the powers and prerogatives of offices. An absolute interpretation of this principle, after all, would give some citizens a greater chance to occupy these positions, for example, if they had opportunities above the threshold, and so the parties to the original position would have no reason to choose such a principle.

Daniels is not entirely clear about how he interprets this principle. His revised principle of fair equality of opportunity requires that people have a fair share of their society’s normal opportunity range and so have access to health care services necessary to correct for departures from normal functioning; but to our knowledge, Daniels never specifies whether he interprets the idea of a *fair share* in either relative or absolute terms.85 However, there are strong reasons to think that Daniels is committed to interpreting fair equality of opportunity as a relative principle. First, Rawls clearly interprets fair equality of opportunity as a relative principle and Daniels’s project is to extend Rawls’s framework to address the question of health justice. If Daniels reinterprets this principle in absolute terms, this would constitute a significant inconsistency with Rawls’s theory.

Second, Sreenivasan argues quite persuasively that Daniels would face significant challenges were he to opt for the absolute interpretation. The relative interpretation, after all, allows one to define the boundaries of a fair share of health by reference to the opportunities of others.86 Were Daniels to opt for the absolute interpretation, he would need to “first define a noncomparative scale of opportunity and then locate a given individual’s permissible lower limit somewhere on that scale.”87 Such an endeavor is not only challenging, Sreenivasan notes, but also conflicts with Daniels’s claim that a society’s normal opportunity range “depends on key features of the society – its historical development and its material wealth and the technological development, as well as important cultural facts about it.”88

The problem with governing the distribution of the social determinants of health with fair equality of opportunity – interpreted as a relative principle – is that doing so has counter-intuitive implications. A relative principle implies that an unequal distribution of the social determinants of health is unjust, *even if such a distribution is beneficial to those least advantaged on the social health gradient*. Such a distribution, after all, would grant one group of people a larger share of the normal opportunity range than others.

As an example, suppose that absolute income is a social determinant of health, but that relative income is not. Suppose further than on an equal distribution of income, a society’s three classes will have the following average incomes and expected quality-adjusted life years (QALYs):

|  |  |  |  |
| --- | --- | --- | --- |
| Distribution 1 | Unskilled | Semi-Skilled | High-Skilled |
| Income | $20,000 | $20,000 | $20,000 |
| QALYs | 75 | 75 | 75 |

Suppose next however that if income is distributed unequally, members of all classes will be better off in terms of both income and QALYs, for example, because the introduction of incentive inequalities leads people to work harder, gain greater skills, and choose more productive occupations:

|  |  |  |  |
| --- | --- | --- | --- |
| Distribution 2 | Unskilled | Semi-Skilled | High-Skilled |
| Income | $30,000 | $45,000 | $60,000 |
| QALYs | 78 | 80 | 82 |

Now, since there is an unequal distribution of QALYs in distribution 2, Daniels’s fair equality of opportunity principle would not permit it. Distribution 2, after all, grants high-skilled citizens a greater share of the normal opportunity range than either unskilled or semi-skilled citizens. This seems deeply counterintuitive however, since all citizens are better off under distribution 2 than distribution 1. Our account, by contrast, implies that distribution 2 is just since it explicitly permits inequalities in the distribution of the social bases of health that improve the health status of those least advantaged on the social health gradient.

Although Daniels can address the problems of inconsistency and incompleteness by extending his principle of fair equality of opportunity to the distribution of the social determinants of health, doing so renders the view normatively implausible. For this reason, we think that our account is superior to Daniels’s.

Conclusion

Our aim in this paper has been to rethink Rawls’s theory of distributive justice in light of evidence regarding the social determinants of health. We have developed a Rawlsian account of the just distribution of the social determinants of health, one that avoids the criticisms to which Daniels’s account is subject. Our account does not claim to be comprehensive since it does not provide guidance regarding government’s promotion of public health or articulate a justification for governments’ duty to ensure that all have access to health care. However, given the impact of the social determinants of health on people’s health, we think the limited focus of our paper is justifiable. In addition, we see no reason to think that our account precludes the development of a Rawlsian account that can address these further problems.

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NOTES

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75. Gopal Sreenivasan, ‘Ethics and Epidemiology: The Income Debate’, *Public Health Ethics* 2, 1 (2009b) p. 46.
76. See Sreenivasan 2009b op. cit., p. 46.
77. Kate E. Pickett and Richard G. Wilkinson, ‘Income Inequality and Health: A Causal Review’, *Social Science & Medicine* 128, March (2015): 316-326.
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79. (2) should not be interpreted to forbid inequalities in the social bases of health that neither worsen nor improve the health status of those least advantaged but improve the health status of those higher up on the social health gradient. Rawls recognizes that a similar type of case could arise with respect to the difference principle, and so proposes that the “lexical difference principle” be applied to ensure that improvements to the better off that have no effect on the least advantaged, are not prohibited. Rawls 1999a op. cit., p. 72.
80. Arnold op. cit., p. 105-106.
81. Arnold op. cit., p. 106.
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83. For example, see Madison Powers and Ruth Faden, *Social Justice: The Moral Foundations of Public Health and Health Policy* (New York: Oxford University Press, 2006); and Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Cambridge, Polity Press, 2011).
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85. Daniels op cit., pp. 44-58.
86. Sreenivasan 2007 op. cit., pp. 22, 29.
87. Sreenivasan 2007 op. cit., p. 29.
88. Daniels op. cit., p. 43.