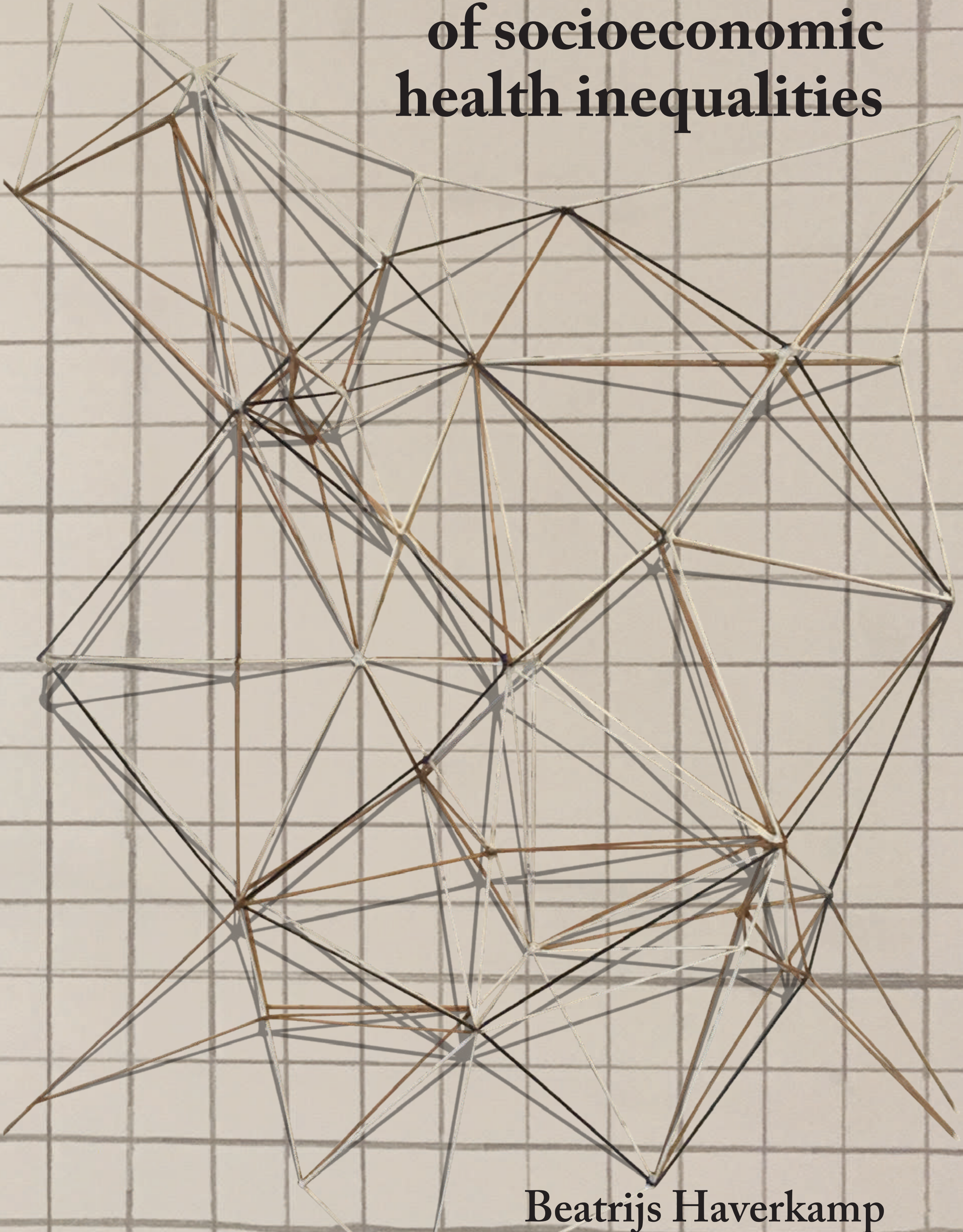
Philosophical investigations of socioeconomic health inequalities



Beatrijs Haverkamp

Propositions

1. Judging whether health inequalities are unjust requires the evaluation of the causes but also of the consequences of those inequalities. (this thesis)
2. To adequately deal with the complexity of the social determinants of health we need to broaden the subject of justice as it is understood by John Rawls.
(this thesis)
3. Interdisciplinary collaboration requires and stimulates humbleness towards one's own discipline.
4. Environmental scientists should pay more attention to the question of how the burdens and benefits of the transition to sustainable energy can be distributed more justly.
5. Television programmes about people from lower income groups tend to stereotype, and thereby miss their chance to stimulate solidarity among citizens.
6. One of the greatest challenges for public health policy is to treat people as agents while acknowledging their dependencies.

Propositions belonging to the thesis, entitled,

'Philosophical investigations of socioeconomic health inequalities'.

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Philosophical investigations of socioeconomic health inequalities

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Introduction

Chapter 1 Introduction

Imagine Mark, a 30 years old Dutch guy who has worked as a car mechanic since he finished high school. According to statistics, he may expect to live at least another 50 years. His life prospect is 4,5 years shorter than that of some of his clients. Like Anna, a woman of Mark's age who just started her first job as a lawyer. She likely has almost 55 life years ahead of her. Moreover, it is highly probable that Mark will face some chronic illness in about 15 years, whereas for Anna, there is a good chance that she will enjoy another 23 years without chronic conditions. Would we annually ask them to rate their own health, we will probably see an even bigger difference between the two, as Mark will report that he perceives himself to be in good or very good health until the age of 60, whereas Anna will probably experience her health to be good or very good at least until she reaches the age 73.

Is this difference unjust? If so, why? And is the 8 year gap in disease-free life expectancy more unjust than the 4,5 years gap in mere life expectancy? Also, how to think of the 13 years difference in their prospects to live in good perceived health? Or is perceived health irrelevant for justice?

Today in the Netherlands, the difference in life expectancy between lowest and highest educated groups[1] is 5 years: persons with a low degree of education may expect to live 79,3 years, whereas persons with an academic degree may expect to live at least until the age of 84,4. When we look at life expectancy in good perceived health, the health-gap is even 14,3 years, as the first group has the prospect to feel healthy until the age of 57,2, whereas the last group until the age of 71,5 (CBS 2017).[2] Similar patterns can be observed in other high-income countries (e.g. Mackenbach 2001). In the UK for instance, where socioeconomic class is indicated by type of occupation, there is a difference in life expectancy of 6 years among men of class 1, and men of class 7. For both British men and women, the disability prevalence rate is higher in classes 5, 6 and 7, than in classes 1, 2, 3, and 4 (ONS 2015). So, the lower one's position in the socioeconomic hierarchy, the more likely it is that one's life is shorter and marked by various health problems.

This fact gives rise to several philosophical questions, two of which will be central in this dissertation. Firstly, how should we evaluate these inequalities? Specifically, are these inequalities *unjust*, and if so, why? The answer to this question is not without implications: If we call something unjust, then there is no question that we must act. An injustice indicates that someone or society has a duty to (try to) alleviate it. Or, as the political philosopher John Rawls famously noted:

> *'Justice is the first virtue of social institutions, as truth is of systems of thought. A theory however elegant and economical must be rejected or revised if it is untrue; likewise laws and institutions no matter how efficient and well-arranged must be reformed or abolished if they are unjust.'* (Rawls 1999, 3).

Secondly, there is the question of how we should understand 'health'. Specifically, are all health measures equally relevant? To indicate health inequalities in high-income countries, researchers use a variety of health measures. In the Netherlands, health inequalities are for example commonly expressed in terms of life expectancy or healthy life expectancy. 'Healthy' is thereby qualified in terms of 'perceived good health', 'good mental health', 'absence of chronic disease', and 'absence of physical disability'. The magnitude of the socioeconomic health gap differs by the measure that is used. Are there reasons to prioritise inequalities in some measures over others?

Before I explain further how these two issues relate and how I approach them, it will be helpful for what is to follow to first briefly turn to the question of how socioeconomic health disparities have (or have not) been addressed by politicians, epidemiologists, and philosophers in the past and today.

I. Socioeconomic health inequalities in historical perspective

Socioeconomic health inequalities as a political concern

Although only in the last decennia problematised as a matter of 'health inequity', the correlation between health and occupation, income and/or education levels, is known to exist since ages. Before governments existed, churches and parishes in European cities in the 17th and 18th century held registers of baptisms and burials, which reveal great differences in life expectancy between people of different social ranks (Mackenbach 1995). Later – in France in 1798, in the Netherlands in 1811, in the UK in 1837 – church registers were replaced or accompanied by governmental registers. In the UK – and probably in other welfare states in the making too – it was thereby believed that 'it was the responsibility of the national office not just to record deaths, but to uncover underlying linkages which might help to prevent disease and suffering in the future' (Acheson 1998, 10). This belief was reconfirmed by the *Beveridge Report* in 1942, that spoke of 'Disease' as one of the five giants on the road to reconstruction and social progress, accompanied by Want, Squalor, Idleness and Ignorance (Beveridge 1942, 6).

Developments and actions in public health in the UK are generally seen as having been of great influence on public health research and policies in other western countries. Not only so in the 19th century and the subsequent rise of public health movements, but also later. Notable is the *Black Report*, published in 1980, named after the commission's chair Sir Douglas Black. Based on the findings by the 'Working Group on Inequalities in Health', the Black Report recommended several policies to monitor and address persisting health disparities related to social class. While ignored by UK's own government, it influenced the common health strategy in the WHO-European Region (Acheson, 1998). By formulating 'health equity' as a central aim, the WHO framed health inequalities as a matter of social justice (WHO 1985).

In the same year the Black Report was published, in the Netherlands, *The Dutch Society for Social Medicine* celebrated its 50th anniversary with a conference on socioeconomic health inequalities. Five years later, the Dutch government agreed with the other European WHO member states to counteract health inequalities. In 1987 a national research programme was started, followed-up by a second one in 1995 ('Programmacommissies SEGV I & II'). The task of these commissions was to advise about the best approach, and to evaluate interventions to reduce socioeconomic inequalities in health and analyse how these could be prevented.

However, in 2003, the Dutch government was criticised by the Netherlands Court of Audit for taking insufficient action regarding socioeconomic health inequalities (Tweede Kamer 2003). In response, the Dutch government repeated its ambition to reduce avoidable socioeconomic health disparities by raising the life expectancy of the lower socioeconomic groups with three years (Ministry of Health, Welfare and Sports 2003). Nevertheless, health inequalities received hardly or no attention by the governments that followed. This silence was broken by Parliamentary questions in 2008, in response to which the Minister of Health presented an elaborate policy strategy to reduce socioeconomic health inequalities both improving structural factors, such as neighbourhoods and social participation, and stimulating healthy lifestyles. The proposals to address socioeconomic health disparities were explicitly motivated by a concern for 'social justice' (Ministry of Health, Welfare and Sports 2008). Despite these ambitious plans on paper, their effects appeared to be minimal (Broeders et al. 2018). Life expectancy overall has increased, but inequalities in health have persisted. It is in the light of their persistence that we can understand the recommendation of the Netherlands Scientific Council for Government Policy (WRR) to shift the focus in public health policies from aiming to reduce health inequalities to trying to utilise the health 'potential' of the whole population (Broeders et al. 2018). Inspired by Michael Marmot's 'proportionate universalism' – the idea that public health measures should address the entire population but in proportion to the degree of the health needs of specific groups (e.g. Marmot et al. 2010), the WRR argues to give extra attention to lower socioeconomic groups.

In the year 2018, the Dutch Minister of Health, Welfare and Sports announced the 'Nationaal Preventieakkoord'. At the time of writing this introduction, it is unclear yet to what extent addressing socioeconomic health inequalities will be a central policy aspiration.

Epidemiological attention to socioeconomic health inequalities

Socioeconomic inequalities in health are often believed to have emerged after the ending of the great epidemics, in 17th and 18th century Europe, at a time when improvements were made in terms of nutrition, housing and private and public hygiene. That is, improvements in factors that were unequally distributed, and for that reason likely resulted in social health disparities (Mackenbach 1995, 1291). But Mackenbach (1995) argues that also before these developments, it is unlikely that the powerful and rich had the same life expectancy as the powerless and the poor. In 14th and 15th century Europe, famine, war and pestilence were the central health threats: threats we may assume to have affected the health of the poor more severely than the rich. Moreover, there is historical evidence that epidemics such as the plague hit the poor the hardest (Mackenbach 1995, 1291).

The fact that socioeconomic health inequalities are a phenomenon that has been known for a long time may explain why it has been central to epidemiological research since the rise of epidemiology as a scientific discipline. Moreover, the speculation Mackenbach describes about how to understand the relation between poverty and illness in the past illustrates how this relation has been subject to debate among epidemiologists in the last two centuries. As Nancy Krieger (1994) mentions:

> *'Much of the research of the 19th century epidemiologists in both Europe and in the United States (…) was motivated or shaped by two central (and connected) debates: (1) whether miasma or contagion was the primary cause of epidemic disease, and (2) whether poverty was the cause or the result of poor health and immorality.'* (Krieger 1994, 892)

Krieger notes that these two debates addressed the fundamental question of biology vs. social factors as causes of disease. Since the beginning of the 20th century, consensus has been achieved that both social and biological factors should be considered.

Regarding socioeconomic inequalities in health, the question of whether poverty is a *cause* or an *effect* of poor health, was resolved at the end of the 20th century. That is, since then, epidemiologists generally agree that the so-called 'selection principle' – i.e. bad health leads to a lower socioeconomic position – accounts only for a small part of socioeconomic inequalities in health. And that the greater part is due to 'causation mechanisms' – i.e. socioeconomic position determines health and not the other way around.

This agreement comes with a shift from talking about poverty to talking about relative socioeconomic position. In this regard, the Whitehall Studies – started at the end of the 1960s in the UK – played an important role. By recording mortality and causes of death of about 17500 civil servants working at the London Whitehouse, a 'social gradient' in health was shown: the higher in the employment hierarchy, the lower disease prevalence. For instance, mortality rate among men with lowest employment grades (e.g. porters and carriers) between 40 and 64 years was roughly three times higher than among the administrators at the top (e.g. Marmot et al. 1984). That there is a 'step-wise' relation between employment grade and mortality, was later confirmed by the follow-up, Whitehall II, that included younger employees and women (e.g. Marmot et al. 1991).

Regarding the question of how precisely this causation mechanism works, epidemiologists have given different explanations. Often, this mechanism is discussed in terms of 'upstream' and 'downstream' determinants (e.g. Braveman et al. 2011). Downstream determinants refer to the material, behavioural and psychosocial factors, such as air pollution, smoking and stress, that immediately cause health problems. Upstream determinants refer to 'the causes that reflect the social structure' of a society (Asada 2007, 14), such as the distribution of income and education level. According to this view, the route from upstream explanatory variables – e.g. income, education, occupation – is explained by downstream explanatory factors – e.g. housing conditions, physical working conditions, nutritional habits, smoking, social support (e.g. Van Lenthe et al. 2004). That is, socioeconomic health inequalities are assumed to exist because socioeconomic position leads to factors that harm people's health. For instance, the fact that car mechanics experience more physical burdens explains that they live less long in good (physical) health.

A slightly alternative view on the causation mechanism is put forward by 'fundamental cause theory' (Link & Phelan 1995). Fundamental cause theory takes some social conditions as 'fundamental causes of disease', if those conditions involve access to social and material resources 'that help individuals avoid diseases and their negative consequences through a variety of mechanisms' (Link & Phelan 1995, 81). Rather than understanding social conditions – e.g. race, socioeconomic status, marital status – as leading to 'downstream' individual explanatory factors, fundamental cause theory takes them as, indeed, the *fundamental* cause, in the sense that

> *'the association [between social condition and health] cannot be successfully reduced to a set of more proximate, intervening causes because the association persists even while the relative influence of various proximate mechanisms changes.'* (Lutfey & Freese 2005, 1327)

The hypothesis that these social conditions are fundamental causes implies that addressing causes of disease on the individual level will not be effective in reducing social health disparities, as this would not change the resources to avoid diseases available to people *given their social condition*. Fundamental cause theory thus explains why in Europe, declines in preventable causes of death are higher among higher educated groups than among lower educated groups, and that socioeconomic inequalities in preventable causes of death are higher than non-preventable causes of death (Mackenbach et al. 2017). Fundamental cause theory differs from the view of 'upstream and downstream determinants' in the sense that it emphasises the perseverance of social health inequalities.

Nevertheless, fundamental cause theory does not answer the question of what *precise* mechanisms are at work in the persistence of socioeconomic health disparities. This question is central to epidemiological research today. Notable is the work by advocates of so-called 'complex system theory'. These epidemiologists understand health as a manifestation of a system in which biology, environments and individuals interact with each other over time. As such, epidemiology entails the study of the interaction between genes, social norms, environmental structures and behaviour, rather than tracking the causal pathways of these factors in isolation from each other (Diez Roux 2011). Studies taking this perspective reveal dynamics between social and biological conditions and thus consider aspects of both causation *and* selection mechanisms in explaining socioeconomic health inequalities.

In studying inequalities in health, epidemiologists have generally not bothered too much about the conceptualisation of health. They have used the variety of health indicators – from self-perceived health to absence of mental and physical illness – and have found the social gradient of health in each of them. And so, we can see that scientific experts in the field today take socioeconomic health inequalities as a well-documented fact for a broad scale of indicators of health. The unresolved question is how exactly they emerge and – importantly – why they persist. Contemporary epidemiology thereby confronts us with the high degree of complexity that characterises the phenomenon of socioeconomic disparities in health.

Socioeconomic health inequalities in philosophy and bioethics

It is only since a few decades that moral and political philosophers show a concern with health itself as a matter of justice. Earlier, for instance in the field of bioethics, the focus was primarily on issues like priority setting and the allocation of scarce resources in clinical health *care* (e.g. Beauchamp & Childress 1979; Daniels 1985).

Also, in theories of justice, health problems themselves have long been seen as a matter of bad luck, determined by nature, and for that reason not as a subject to (distributive) justice. This is most clear in Rawls's influential *Theory of Justice*, in which health is not treated as a social good, but as a natural good (e.g. Rawls 1999, 54). In a review of a *Theory of Justice*, Arrow (1973) rightly questions what Rawls's principles could tell us about how to treat the haemophiliac person who needs more resources than average. Taking up this challenge for Rawls, Daniels (1985) extends Rawls's theory with his *Just Health Care*, arguing that the protection of health is a requirement of Rawls's principle of fair equality of opportunity and that justice as fairness therefore requires universal access to health care. In later years, Daniels elaborates and applies this argument to socioeconomic health inequalities, as he becomes aware of the existence of the social determinants of health. Acknowledging the influence of the latter he declares that 'Medical care is, figuratively speaking, "the ambulance waiting at the bottom of the cliff"' (Daniels 2008, 79; cf. Daniels et al. 1999). With *Just Health*, Daniels (2008) has importantly contributed to the emergence of what could be seen as a new field in analytic political philosophy, namely that of 'health justice'.

At least as influential in this regard is the capability approach. A concern with (differences in) health was at the heart of Sen's introduction of the very notion of capabilities. In fact, we hear echoes of Arrow's criticism of Rawls, when Sen argues that utilitarian and resource theories of justice cannot satisfactorily deal with the 'hard cases', such as the cripple, the disabled or people with special health needs (Sen 1979, 215). Rather than focusing on the distribution of resources, Sen argues that the focus should be on the distribution of capabilities: people's 'real opportunities to do and be what they have reason to value' (Robeyns 2016). This supports the view that often the diseased and disabled need more resources, care and support than their healthy co-citizens.

Within capability theories, health is not only seen as a factor to be taken into account when determining what a person needs to achieve other capabilities: the capability to be healthy has also been defended as a separate capability in need of protection (e.g. Nielsen & Axelsen 2017; Nussbaum 1992; Prah Ruger 2009; Ram-Tiktin 2011; Venkatapuram 2011). For instance, Nussbaum defends the view that each person should have the capability to a minimal level of 'Life' and 'Bodily Health' (e.g. Nussbaum 1992). And in *Health Justice*, Venkatapuram reconceptualises health as a 'meta-capability' to achieve Nussbaum's central human capabilities (e.g. Venkatapuram 2011; see chapter 2, 5 and 8).

Defences of health as *itself* a capability that should be secured for social justice, help to make a case for the relevance of health for justice. However, they are less helpful for settling difficult issues of what this exactly requires. For instance, if having a capability to health is to have the *effective* opportunity to be healthy, this gives rise to the question of to what extent social determinants of health – e.g. income and education – are to be taken as *constituting* a capability to health, and thus as to be protected for health's sake.

The question of what justice requires for the protection of health links to a key question to current debates about the (in)justice of health inequalities. Namely that of how to distinguish just from unjust health inequalities. That is, when should we speak of *inequalities* in health and when of *inequities* in health? The notion of health equity as coined in a WHO-paper by Margaret Whitehead (1990) has been central subject of debate. This view opposes health inequalities that are ‘unavoidable’ and ‘inevitable’ to those that are ‘unnecessary’ and ‘unjust’. The view that avoidable health inequalities are unjust is prominent in several later health policy documents (e.g. WHO 2013). Philosophers have been keen to point out that ‘avoidability’ offers little moral guidance if nothing is said about e.g. individual responsibility for health. That is, avoidability evokes the question ‘avoidable by whom?’ To the extent that health is an individual responsibility, there may be less reason to see inequalities in health as raising concerns of justice. Moreover, the mere fact that health inequalities are avoidable is not enough nor necessary to judge them as unjust. For instance, small health inequalities may be easy to avoid, yet not be a concern for justice. On the other hand, some great health inequalities may be very hard to avoid, yet nevertheless be thought of as unjust. And so, there is the question of where to draw the line between health inequalities that are avoidable and that are deemed impossible – or unreasonable – to avoid (e.g. Preda & Voigt 2015; Wilson 2011). While the question of whether inequalities are avoidable is not irrelevant, there is more to say about the distinction between just and unjust health inequalities.

This becomes especially clear if we zoom in on the moral assessment of *socioeconomic* health inequalities. Regarding these specific health inequalities, a central point of discussion is whether these inequalities should be evaluated ‘directly’ or ‘indirectly’. That is, should we localise the primary injustice in the *health* inequalities per se, or in the *socioeconomic* inequalities to which health levels are related? Evaluating health inequalities directly means that we take avoidable health inequalities to be an independent – or ‘freestanding’– moral concern and as to be evaluated by an independent distributive rule. By indirect – or ‘derivative’ – evaluation we derive our judgement about health inequalities from how we evaluate the underlying socioeconomic inequalities (Peter 2001, 160; Sreenivasan 2009; 2014). That is, health inequalities are only unjust if and as far as they result from unjust social circumstances. This distinction between direct and indirect evaluation regards the key moral question of what the focus of our justice evaluations of socioeconomic health inequalities should be: inequalities in health or inequalities in the social determinants of health?[4]

Besides, this question could be understood as telling us what the focus of *addressing* socioeconomic health inequalities should be. For if the injustice in health distributions is prior to, or independent of socioeconomic health inequalities (direct evaluation), this means that reducing inequalities in health or diminishing health deprivations is first due. Whereas if the injustice is to be localised in the socioeconomic disparities (indirect evaluation), it is socioeconomic injustice that needs to be addressed first.

And so, while ethicists and political philosophers have now widely acknowledged socioeconomic health inequalities as raising concerns of social justice, the question remains of *how* exactly we should evaluate them.

II. Research questions, aims, and structure

All in all, there seems to be broad consensus between politicians, the WHO, and quite a few philosophers, that systematic inequalities in health between socioeconomic groups appear to be unjust. But are the arguments provided for this view sound? This question is important because the mere intuition that they are unjust is no justification for addressing these inequalities and perhaps redistributing resources. At the same time, if socioeconomic inequalities in health are indeed unjust, arguments for this can help to make a stronger case for addressing them.

Moreover, there is the question of which health inequalities *exactly* we should focus on. As noted above, inequalities in health are measured in different ways: sometimes biomedical indicators are used, such as ‘life expectancy’ or ‘life expectancy without chronic diseases’. Sometimes inequalities in health are indicated by subjective measures such as ‘self-perceived health’. Sometimes health is indicated by abilities such as being able to walk, or to dress yourself without help. And sometimes the absence of feelings of depression, or anxiety are taken as indicating health.

This raises the question of whether all of these measures are equally morally relevant. Especially if inequalities in health strike us as unjust, we should reflect on, and determine which health inequalities exactly deserve our primary attention. This would be relevant for policy making as it would bring in focus in policies concerned with health inequalities. For instance, it may be that addressing unequal disease-prevalence requires different policies than addressing inequalities in as good experienced health, or inequalities in basic daily abilities. But it might also be that inequalities in some health measures are simply more unjust than in other measures. The question that forms the starting point of this dissertation is therefore: *which health inequalities deserve our focus if we are concerned with social justice?*

This dissertation, however, will only provide some directions of thought that would contribute to answering this question. Aiming to actually answer it would have been a presumptuous undertaking. For with this one question, two age-old philosophical issues come together: 'how should we understand 'health'?' And: 'what should we understand by 'justice'?' By investigating these two issues in relation to socioeconomic health inequalities, this dissertation can be said to address, more specifically, the following two distinct questions. Firstly, *what health concept should be central in policies concerned with health equity?* Secondly, *how should we evaluate socioeconomic health inequalities?*

In exploring these questions, the aspiration is to contribute to philosophical discussions, while being relevant for (policy)practice. In order not to lose sight of real-world questions – as philosophers may sometimes be inclined to do – due consideration is given to what is empirically known about *both* conceptualisations of health in practice, and about the very complex phenomenon of socioeconomic health inequalities. Especially regarding the part on justice evaluations, this dissertation could therefore be taken as an exercise in what political philosophers characterise as 'non-ideal theory'. That is, while seeking solid arguments, it acknowledges that theories of justice may not always be capable to deal satisfactorily with the complexities and chaos that mark the real world. As I will further discuss in the discussion chapter, while ideal theory and principles for perfect justice may be needed for the evaluation of inequalities, it is only by an engagement with the complexities of the real world that we can also start to think about how to make that world more just.[5]

Although the two questions regarding health and regarding justice evaluations are separate questions, they may well bear upon each other. For on the one hand, the question of which health concept should be central in health equity policies may depend on what we deem relevant for justice. On the other hand, what we understand by socioeconomic health inequalities as subject of justice evaluations may depend on which understanding of health we deem adequate. This confronts us with a dilemma regarding the structure of the dissertation: where to begin? Assuming that clarifications of central concepts is a good start, the first part engages with the question of how to conceptualise health. And so, chapters 2 and 3 offer a theoretical and an empirical exploration of health concepts. Chapter 4 discusses what normative relevance these conceptual studies to health could have for health equity policies and thereby anticipates the discussions about justice in the second part. Chapters 5, 6, and 7 address the question of how to evaluate socioeconomic inequalities in health in the light of social justice. Each of these three chapters has a different focus of evaluation, respectively the health inequalities as such, their causes, and their consequences. Chapter 8 summarises the most important findings and discusses questions the other chapters may have raised but that remained unaddressed.

In what follows, I briefly outline the order of the chapters and clarify the sub-questions each of them addresses.

Part I: The meaning of health

Before explicating how concepts of health are studied in this dissertation, we may ask whether we *can* study the meaning of health and whether we *should* do so. The question to what extent it is possible to investigate the meaning of health, is for instance raised by a phenomenological thinker like Hans-Georg Gadamer (1996). He suggests that as soon as we objectify the term ‘health’ to grasp its meaning, it slips away. Gadamer thereby speaks of ‘the enigma of health’:

> *'But what then is health, this mysterious phenomenon which we all know and yet somehow do not know precisely by virtue of the miraculous character which attaches to being healthy?'* (Gadamer, 1996, 110)

Also, Georges Canguilhem talks of health as the 'truth of the body', referring to Leriche's idea of health as 'life lived in the silence of the organs', as something that cannot be the object of scientific knowledge, only of the experience of not being bothered by physical discomfort (e.g. Canguilhem 2012 [1990], 468).

Views like these suggest that it is an idle undertaking to try to capture the full meaning of health. I will not discuss these philosophical observations in depth but that does not mean that I ignore their relevance. In fact, I think they are very truthful to what being healthy means in our daily experience. And so, I consider theories and concepts of health as attempts to articulate *aspects* of what it means to be healthy. Even if we will never be fully able to grasp 'the' meaning of health in words, capturing different aspects of health may be helpful when we aim to make normative sense of the fact that the experience of being healthy is unequally divided among populations.

This brings me to the question of why we *should* study about the meaning of health. Notably, Hesslow (1993) has argued that philosophical discussions on the concept of disease – understood as the counterpart of health – are of no use. Using the analogy of a car mechanic, Hesslow shows that the latter has no need to know the definition of a car defect, to fix a broken car. If one takes health and disease as purely scientific concepts – as Hesslow does – one may indeed conclude that studying concepts of health and disease is of little relevance. However, if we think – as I do – that health and disease are normatively laden concepts, then there seems to be a point in examining their meaning. For instance, in the Netherlands, the Minister of Public Health has the constitutional duty to 'protect the health of its citizens', and as noted above, researchers and policymakers have different ways to measure and monitor population health. For them, as for political or ethical discussions on health policies, it is important to clarify what is meant when health is said to be promoted or protected.

For that reason, *chapter 2* discusses the question of how health is understood by theories of health and how these theoretical concepts differ from each other. The focus is thereby on philosophical concepts that also figure in contemporary (analytical) debates about health and justice: the ones by Boorse, Nordenfelt and Venkatapuram. In addition, because of the policy-oriented question to which this analysis aims to contribute, it discusses the WHO-definition of health, and Huber et al.'s more recently proposed alternative. Rather than arguing for one concept of health as the best or most adequate, this chapter argues that the point of studying health concepts is to recognise the implicit norms involved in different concepts and definitions of health. If health concepts have any function, it is that they may help to clarify or make explicit the (often implicit) aims of our health policies and practices, and as such can guide and reorient normative reflection on policies and practices. A comparison of these five concepts reveals their differences and similarities and shows how each of the concepts highlights aspects of health that could be relevant in different practices, depending on the aims, values and norms of the particular practice.

Because we may question why it should be up to philosophers to demarcate the meaning of health, *chapter 3* reports a small-scale study into the question of what Dutch citizens declare health to mean and whether there are differences in conceptualisations of health between different socioeconomic groups. This study is in line with studies by medical sociologists who have investigated the meaning of health by studying how ordinary or 'lay' people understand health. The question of how ordinary citizens understand health is deemed relevant, because health is a partly evaluative term and public policies should – to some extent – reflect what is valued by the citizens that are subjected to these policies. By using the method of 'concept-mapping', results are presented in so-called 'concept maps'. They show that all socioeconomic groups have a broad or multidimensional understanding of health. Further analysis reveals differences between the conceptualisations of health by lower and higher educated people, such as differences in functional versus hedonistic views, and passive versus active attitudes.

Chapter 4 discusses the question of what relevance these studies to conceptualisations of health could have for health equity policies. This chapter therefore elaborates on two ideas that were briefly suggested in chapter 2 and chapter 3. Firstly, it considers the idea that for health equity policies, some dimensions of health are more relevant than others. Considering the justice-related demands of impartiality and equal treatment, there is reason to think that health equity policies should focus upon objective and universal dimensions of health. However, it appears that we actually have good reasons to also use subjective health measures and allow for some relativity in health standards. Secondly, this chapter examines further the idea that public health policies should resonate health concepts that prevail in society, as suggested in chapter 3. This idea is here interpreted as a concern for recognition, and as being potentially in tension with concerns about adaptive preferences. That is, while conducting studies like the concept map study is important for recognising the views of marginalised groups, the results can also be interpreted as revealing health norms adapted to socioeconomic circumstances. To prevent public health policies applying double standards, it is argued that views of ordinary citizens should be taken into account but should not be uncritically translated into policy aims that differ per social group. The upshot of this fourth chapter is that a concern with impartiality and equal treatment provides no decisive reason to privilege some health measures over others, and that a concern with recognition gives reason to endorse (society)relative health measures.

Part 2: Evaluating socioeconomic health inequalities in the light of social justice

Since the conceptual studies to health as such do not provide reasons to single out some health aspects as more relevant for justice than others, the following chapters address the question of how we should evaluate socioeconomic inequalities in health within countries, *as they are commonly measured.* That is, in terms of (subjective and objective) healthy life expectancy or in terms of disease and disability prevalence. To what extent can we explain and justify the intuition that such inequalities are unjust?

Apart from the three justice-related concerns of impartiality, equal treatment and recognition that figure in the fourth chapter, more can and should be said about what to understand by justice in general and my approach to it. Miller (2017) notes that if there is anything that comes close to a 'core concept' of justice, it might be traced to Roman Law, where justice is defined as 'the constant and perpetual will to render to each his due'. The question is of course *what* one is 'due'. I assume this to be dependent on how we relate to each other, and that justice-claims can only be made if there is another actor (i.e. a person, institution, government, organisation, etc.), that we can ascribe a responsibility to fulfil that claim (cf. Anderson 2010a). For this reason, I do not discuss so-called 'luck egalitarian' approaches to health and justice (e.g. Segall 2009) as luck egalitarians assume that (in)justice can also have a 'cosmic' cause. According to them, victims of naturally caused diseases are not unlucky, but suffer injustice. Contrarily to luck egalitarians, I take it that bad luck does not belong to our register of judgements of justice. By adopting a relational understanding of justice, 'each due' is the answer to the question of 'what do we owe each other?' (e.g. Daniels 2008, 140). In this dissertation, this is narrowed down to 'what do we – as members of the same society – owe each other in terms of health?', a question that shows the oddity that comes with inequalities in health. For we cannot distribute health itself, and so no one can make a claim to be *actually* healthy, we can only make a claim to the opportunity (or 'capability') to be healthy.

To see whether we can nevertheless think of health inequalities as being of independent moral concern for justice, this second part takes the above explained distinction between direct and indirect evaluation as a starting point. As such, the second part centres around the question of what the focus of our justice evaluations of socioeconomic health inequalities should be: inequalities in health or inequalities in socioeconomic status? Moreover, this question could be understood as telling us what the focus of addressing socioeconomic health inequalities should be. For if the injustice in health distributions is prior to, or independent of socioeconomic health inequalities (direct evaluation), this means that reducing inequalities in health or diminishing health deprivations is first due from the perspective of health justice. Whereas if the injustice is to be localised in the socioeconomic disparities (indirect evaluation), it is socioeconomic injustice that needs to be addressed first.

Therefore, *chapter 5* first considers the approach of direct evaluation, which comes with the question of what the right distribution pattern for health is. While an equal distribution pattern in health is commonly focused upon in health equity policies, quite a few philosophers have defended the idea that social justice should aim for *sufficient* health. This proposal deserves further examination, because it could imply that the health inequalities observed in some countries are not unjust if the least healthy groups are still healthy enough.

Even though sufficient health for all might be an appealing moral aim, it comes with the challenge of determining what to count as being healthy enough. I discuss two ways in which this could be done. One is to let the minimum health level depend on what is achievable, put differently, on what health deprivations are avoidable, in a given society. This leads us to the question of what health deficits a society is *due* to avoid, and thus demands a concern with the distribution of the social determinants of health. A second way is to derive a health threshold from an ideal that indicates what it is that we need to be sufficiently healthy *for,* thus taking health as being of instrumental value for another goal or ideal. By explicating what these two routes could imply in the light of relational equality, I pave the way for the next two chapters.

For the first route, i.e. understanding sufficient health as a question of what health issues a society is due to avoid, *chapter 6* discusses to what extent Daniels's theory of health justice provides a satisfactory way to morally demarcate the category of avoidable health inequalities. Daniels proposes an indirect evaluative approach, by arguing that we should evaluate socioeconomic health inequalities in the light of Rawls's principles of justice as fairness. But the suggestion that Rawls's principles regulate the social determinants of health neglects the fact that not all social determinants of health belong to society's basic structure as conceived of by Rawls and are thereby not subjected to the principles of justice. To capture the social determinants of health in their full complexity, a broadened understanding of society's structure in accordance with Young's notion of social structural processes is proposed. This renders the question of avoidable health inequalities into a question of what we can expect at the side of the actors that uphold and participate in the social structures that lead to health inequalities.

Chapter 7 explores the second route suggested in chapter 5: that people have sufficient health if they can function as equals in society. Therefore, this chapter examines the question to what extent having poorer health than others may deprive people of the capabilities needed to live on equal standing. It identifies three (relational) injustices that result from socioeconomic inequalities in health: the risk to unequal pension enjoyments, unequal risks to stigmatisation and unequal risks to unemployment. These examples of unjust consequences of health inequalities illustrate what could be taken as an additional form of indirect evaluation. Apart from deriving a moral judgement from our evaluation of the social determinants of health, we may also derive it from the effects that health inequalities have. This additional form of evaluation is helpful in so far it is realistic to assume that socioeconomic inequalities in health will persist, since not all social determinants of health can be equalised and the question of what should be done in terms of addressing the social determinants will remain contested. The perspective of relational equality thereby helps to see how unjust effects of health inequalities can be mitigated by adjusting social arrangements and material circumstances.

Chapter 8 summarises the most important findings on health concepts and justice evaluations separately, and addresses some of the many questions that the foregoing chapters may have raised but left unaddressed. Regarding the first part on health, the discussion chapter aims to clarify what I think is after all the relevance of conceptualising health and how to understand the proposal of considering lay views on health. Regarding the second part on justice evaluations, it discusses how to understand my take on distribution patterns, the distinction between direct and indirect evaluation, the role of ideal/non-ideal theory, the notion of relational equality, and the place of personal responsibility for health. This last chapter concludes by a list of recommendations for public health policies and research.

Notes

1. The terms ‘lower’ and ‘higher’ educated have become subject of debate, and rightly so, as ‘lower’ and ‘higher’ may be taken as indicating a difference in how differently educated groups are valued. The alternative proposed is to talk about respectively ‘practically’ and ‘theoretically’ educated (e.g. Witteman 2018). However, I will use the terms ‘lower’ and ‘higher’ educated as well as ‘lower’ and ‘higher’ socioeconomic position for reasons of consistency with the terms used in e.g. chapter 3. Hopefully, this is not taken as disrespectful to those with ‘practical’ or less years of education.

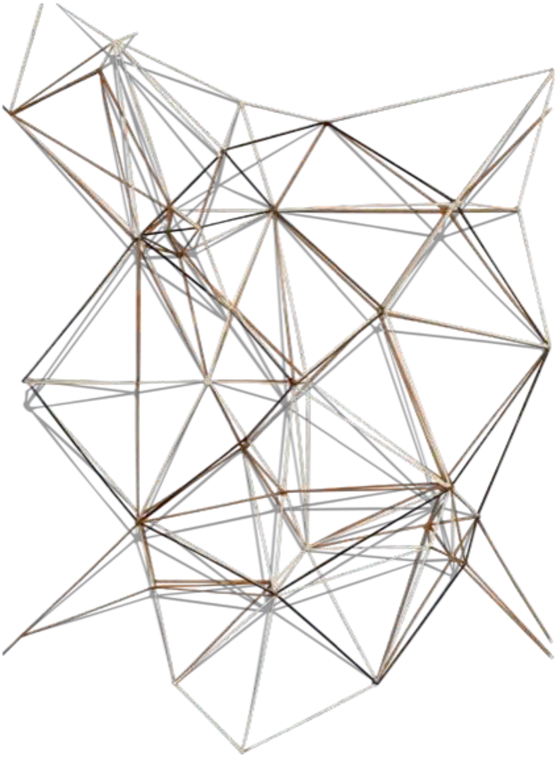
2. These numbers are for new-borns, and thus slightly differ from the numbers in the example of Mark and Anna.

3. Pairing-up poor health and immorality may sound outdated, but as the phenomenon of health-related stigmatisation, as well as contemporary discourses around individual responsibility for health show, health and morality are still tightly associated notions (cf. Ayo 2012; Carey et al. 2017).

4. As I will show in chapter 6, a challenge for indirect evaluation is what exactly to understand by the social determinants of health.

5. I here understand the distinction between ideal and non-ideal theory primarily in line with ‘end-state’ and ‘transitional’ theory, although I also discuss it as ‘full compliance’ and ‘partial compliance’ theory in chapter 6 (cf. Valentini 2012). For a more elaborate discussion of ideal and non-ideal theory, see chapter 8.

PART I:
The meaning of health



Chapter 2

A practice-oriented review of health concepts

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Chapter 2 A practice-oriented review of health concepts

Introduction

The aspiration of theoretical debates about health is generally to identify one specific definition or concept of health as the most adequate, consistent, coherent or 'common sense' (e.g. Boorse 2014, Huber *et al.* 2013, Nordenfelt 1987, Venkatapuram 2011). This presupposes that there is something the concept should be consistent or coherent *with*, or something the concept should be adequate *for*. In this chapter, we propose that this 'something' is ideally a particular health practice. We argue that if we want health concepts to be relevant for practice, the quest for a health concept is a normative quest. That is, a quest for a concept that should guide particular health practices in their formulation of and reflection on goals and priorities. Our aim is to show how a pallet of different health concepts can serve critical reflection on existing health practices, as it provides us with alternative perspectives on health. We conclude that, given the variety of the purposes of practices, different practices may need different concepts.

In order to bring into view which concepts of health recent philosophical and policy-oriented debates have to offer for practice, the chapter starts with a brief description of five prominent concepts of health. These five concepts are health as 1. absence of disease (Boorse 1977, 2014); 2. the (second order) ability to realise your vital goals (Nordenfelt 1987); 3. the 'meta-capability' to achieve a set of basic capabilities (Venkatapuram 2011); 4. a state of complete physical, mental and social wellbeing (World Health Organization (WHO)); 5. the ability to adapt and self-manage in the face of social, physical and emotional challenges (Huber *et al.* 2011). The aim of this first part is only to show that each of these health concepts captures a relevant aspect of health. We thus do not claim to give an exhaustive overview.[1]

In the second part, we classify these concepts by identifying some central distinctions which may finally help us to structure reflection on the understanding of health in particular practices. Before illustrating how this reflection could work out, we will focus in section III on the question of why we should not aspire for one single concept of health. We argue that since different health concepts share different features or assumptions, we should understand them in a Wittgensteinian way: as members of a family, showing several similarities without being identical or sharing an essence. Moreover, comparing different concepts of health, shows that 'health' is a 'thick concept' in the sense that it both describes and evaluates. To the extent that different practices vary in purpose and character, ideas about what conditions are normal or valuable may vary too. The last part shows how reflection on practice-guiding concepts could look like, by briefly exploring three specific health practices. We suggest for each of them which concepts and conceptual features might be considered as most relevant.

It will appear that this search for coherence between theoretical assumptions and practical aims requires a constant reflection on ideals and existing practices.

I. Five concepts of health: a brief overview

Health as absence of disease (Boorse)

The Bio-Statistical Theory (BST) of health brings forth perhaps the most controversial concept of health, as it is widely discussed and criticised by philosophers. We will not reformulate all the criticisms the BST has had to endure, but primarily focus on what it says.

Boorse's aim is to formulate a theoretical concept of health that captures as well as possible the (western) medical-textbook use of the term, in which health is essentially understood as absence of disease. Taking the AMA *Standard Nomenclature* as the reference point to denote the broad range of diseases that are recognised by medical theory (Boorse 1977, 545), leads him to the concept of health as a condition of statistically normal, biological functioning (Ibid., 542). 'Biological functioning' is thereby understood as the functioning of body parts and physiological systems that contribute to the biological goals of reproduction and survival. 'Statistically normal' refers to the performance level of these part-functionings that is typical for the species to which the organism belongs. Or, to put it negatively: health is the complete absence of disease, whereby disease is defined as a state that 'reduces one or more functional abilities below typical efficiency' (Boorse 2014, 3).

Since it is both statistics and biological theory about the species design that tells us what to count as health, the BST claims to identify objective criteria to diagnose whether an organism is healthy. The question of how we respond to the diagnosis in medical practice or public health policies is thereby seen as a separate normative question:

> *The normal-pathological distinction is a reasonable foundation for medical practice because biological normality is almost always in the interest of the patient. Where this presumption fails, however, as with continuous fertility, other values take precedence over health. Although the value of health is usually important, it is also limited.* (Boorse 1997, 24)

So, for Boorse, 'health' or 'being free from disease' is not *necessarily* valuable in itself, since it is understood as a purely descriptive quality of an organism. The BST's pretention to provide a naturalistic, i.e. non-evaluative, concept of health has been contested by several authors (e.g. Engelhardt 1974; Fulford 1989; Kingma 2007).[2] Despite of these important and mostly fair criticisms, we take it that the bio-statistical theory of health cannot be dismissed altogether, as it roughly coheres with how the term is used in medical contexts. More in general, Boorse's theory captures a common intuition that having a disease means that one's health is diminished.

Health as the ability to achieve vital goals (Nordenfelt)

The BST may capture the idea that health is related to disease or illness, but its theoretical approach seems to ignore the very idea that we normally speak about health as something that matters to us as human agents. It is this ordinary use of the term Nordenfelt wants to grasp, by adopting a more holistic view that moves away from Boorse's focus on part-functioning and by acknowledging the normative dimension of health, thus rejecting naturalism. Nordenfelt defines health as the *second order* ability to achieve so-called ‘vital goals’.[3] The goals to which our action is oriented are called ‘vital’ if their accomplishment is necessary to achieve minimal happiness. Minimal happiness is defined by Nordenfelt as a condition in which all the things that are of high priority to a person are just as he or she wants them to be (Nordenfelt 1993, 67).

It is important to see that for Nordenfelt, there is a strong relation between health and minimal happiness, yet the two do not imply each other. To understand this, we should look at his notion of a ‘second order’ ability. Where a first order ability refers to the practical possibility or opportunity a person has, a second order ability refers to a person’s *ability to achieve* such a first order ability. This second order ability is an ‘internal’ ability, that is, one’s mental and bodily capacities independent of external circumstances, whereas the first order ability refers to actually being in favourable circumstances. We can then see that health – being a second order ability – is neither sufficient, nor necessary to achieve minimal happiness. For instance, someone who has the vital goal to be a carpenter, might be *in principle* able to become one, without actually being in the position of having a carpenter job, or without getting the chance to learn the right skills. Due to a lack of the right circumstances, she cannot achieve one of her vital goals, and therefore not be minimally happy. Would we instead think of a person working as a carpenter (and for whom this is a vital goal) who loses one of her arms, she thereby loses her second order ability to nail and hammer. But if she receives an arm prosthesis and the right training, she regains her first order ability, that is, the opportunity to pursue her carpenter job again. She can thus achieve minimal happiness by receiving social and physical support, without *herself* having the ability to achieve this vital goal.

This notion of a second order ability helps Nordenfelt in his ambition to develop a concept of health that captures our ‘ordinary intuitions such as they are expressed in ordinary language’ (Nordenfelt 1987, 283).[4] According to Nordenfelt, it would be odd to call a person ‘unhealthy’ if she wants to become a carpenter, but cannot due to unfavourable circumstances. And in the same way would it be odd – according to Nordenfelt – to call someone who lacks one arm 'healthy', even if she did have a well-functioning prosthesis.[5]

Health as 'the second order ability to achieve vital goals', indeed seems to grasp quite well our ordinary use of the term. That is, health is often seen as an ability of the body and mind, and something that contributes to, but is not identical with, wellbeing.

Health as (meta-)capability (Venkatapuram)
Motivated by a concern for 'health justice', rather than by a concern for ordinary language, Sridhar Venkatapuram argues for a concept of health that explicitly rejects the distinction between (internal) ability and circumstances (Venkatapuram 2011, 2013). The primary reason for this is that he wants a stronger recognition of the various social and material determinants of health. According to Venkatapuram, health is a 'capability' – in the sense of the term as developed by Amartya Sen – to achieve a set of 'central human capabilities' – as they are formulated by Martha Nussbaum. So, being healthy means that, given your psychological, physical, social and material conditions, you can achieve the set of capabilities (that is, the opportunities to achieve specific beings and doings) that are listed by Nussbaum as necessary constituents of a good human life (Nussbaum 1999, 234).

In essence, Venkatapuram's account of health leans on Nordenfelt's concept of health. Both focus on the human agent who seeks to achieve things that are important to him or her in life. And both think that it is not 'the achievement of vital goals [or capabilities], but the *ability to* achieve them that defines health' (Venkatapuram 2015, 7). Moreover, they share the idea that health should be conceived in relation to a set of goals or activities that are somehow more important than other goals or activities. Health, according to Venkatapuram, is therefore not simply one capability among others, but a capability 'to achieve or exercise a *cluster* of capabilities' (Venkatapuram 2011, 143). For this reason, he coins the term 'meta-capability', without which one is deprived of other 'basic' opportunities.

Nevertheless, Venkatapuram's concept of health departs from that of Nordenfelt in two respects. The first is the already mentioned rejection of health as an exclusively 'internal' affair. Venkatapuram (2015) argues that the boundary between what is internal and external to the agent, is actually not so easy to indicate. We can think of medication use and its physical or mental effects to see this point: is the use of drugs external or internal to the agent? But according to Venkatapuram, we should also say that changes in an agent's material and social circumstances can imply a change of that agent's health. E.g. if we think again of the carpenter who loses her arm, and whom Nordenfelt considered to be in poor health, Venkatapuram's concept of health would take this person to be healthy, as soon as she can take up her work again by receiving training and an arm prosthesis. Her health capability is thus constituted partly by two 'external' factors: the arm prosthesis, and the training to use it effectively.

Secondly, contrary to Nordenfelt, Venkatapuram rejects the idea that health should be related to the fulfilment of individual preferences, because preferences strongly depend on, or can be adapted to the local circumstances and cultural norms, which could be disadvantageous to specific individuals or groups. Venkatapuram therefore argues that a concept of health should instead provide a critical instrument with which we can assess people's health regardless of what they themselves consider to be normal (Venkatapuram 2013). For instance, the vital goals of women and girls in patriarchal societies should not depend on the social position their society ascribes to them and that they as such have endorsed. The concept of health as a meta-capability to achieve all the central human capabilities is supposed to enable us to judge e.g. that if a woman cannot build up a social life outside of her home and family life, her health capability is reduced, *also* if she herself does not experience this as problematic.

Health as a meta-capability featured in a special issue of *Bioethics*, and despite its conceptual difficulties, it is praised for providing a theoretical framework for global health justice (Buyx, Kollar, Laukotter 2016).

Health as complete physical, mental and social wellbeing (WHO)

The health concepts discussed so far, are developed within philosophical debates which generally aim to formulate necessary and/or sufficient conditions in order to count a person or organism as healthy or not. Since our approach is pragmatic in the belief that discussions about concepts make most sense if we evaluate them from the perspective of particular health practices, we will also discuss two concepts of health that are influential in practice, but not equally philosophically elaborated. Although these concepts are theoretically less spelled out, they are worth discussing because both reveal distinct conceptualisations of the relations between health, disease and wellbeing.

The first we discuss here is the often criticised WHO definition of health, which dates from the WHO's constitution in 1946, stating that 'health is a state of complete physical, mental and social wellbeing and not merely absence of disease or infirmity' (WHO 2006, 1). The addition that health is not merely absence of disease, suggests that, like Venkatapuram and Nordenfelt, the WHO considers disease in principle as only one among other health-affecting factors. On the other hand, it can be distinguished from the above discussed concepts in its identification of health with wellbeing, instead of conceiving health as *contributing* to wellbeing.It is for this reason that the WHO definition is often rejected for being too broad as a concept of health and for being too idealistic.[6]

But a mere rejection of it might ignore the high humanitarian ambitions of the World Health Organization right after the Second World War. As the Constitution's first article states: 'The objective of the World Health Organization (...) shall be the attainment by all peoples of the highest possible level of health' (WHO 2006, 1). So, rather than as a definition, the idea of health as complete wellbeing should be seen as an ideal, an aspiration for 'all peoples'.

At the same time, the WHO factsheet on 'The Right to Health' (2008) narrows down the ideal by specifying the things to which people are morally entitled regarding their health. These particular health-entitlements include, among others, the right to prevention, treatment and control of diseases; access to essential medicines; maternal, child and reproductive health; and equal and timely access to basic health services (UN&WHO, 2008, 3-4). We thus see that in this later document, the identification of health with complete wellbeing is limited by an emphasis on the WHO's minimal requirement of 'absence of disease or infirmity'.

The WHO definition of health as complete wellbeing is criticised for being unachievable, but it may be questioned whether such high aspirations are as such problematic when appealed to in the context of global health.

Health as an ability to adapt and self-manage (Huber et al.)

A group of international health experts argue in Huber *et al.* (2011) that the WHO's notion of health as complete wellbeing is outdated and therefore useless, since it has become 'normal' that people live for decades with chronic diseases. In this context, the WHO definition leaves 'most of us unhealthy most of the time' (Ibid., 1). Moreover, the authors argue that considering chronically ill people as unhealthy for the rest of their lives, disregards the fact that those people might still lead a fulfilling life and experience wellbeing. A third point of critique entails that the term 'complete' makes the WHO definition neither operable nor measurable (Ibid., 2). The alternative that is proposed is 'health as the ability to adapt and self-manage in the face of social, physical and emotional challenges'. The authors thus remove any reference to disease, yet they stay true to the 'health domains' coined by the WHO, that is, physical, mental and social health.

In their 2011 paper, it is (minimally) indicated what this notion of adaptation and self-management means in each of these domains. Regarding physical health, the ability to adapt and self-manage means that one is capable of 'allostasis', a physiological coping strategy through which one can protect oneself against physical challenges, reduce the potential for harm, and restore an (adapted) equilibrium (Ibid.). In the domain of mental health, adaptation and self-management entails coping with or recovering from strong psychological stress and to prevent post-traumatic stress disorder. It is also referred to as having a 'sense of coherence', a concept formulated by the sociologist Aaron Antonovsky. This sense of coherence is the ability of 'enhancing the comprehensibility, manageability and meaningfulness' of difficult situations (Ibid.). Lastly, health in the social domain is explained as people's capacity 'to fulfil their potential and obligations, the ability to manage their life with some degree of independence despite medical conditions and to participate in social activities including work.' It also implies a 'balance between opportunities and limitations' (Ibid.). In more general terms, the authors argue that they give a central place to 'functioning, resilience and self-governance' (Huber *et al.* 2013, 7).

After formulating the concept of health as the ability to adapt and self-manage and its specification to the three domains, the authors have investigated to what extent this concept finds support among different Dutch 'stakeholders' in the health sphere. They interviewed insurers, patients, citizens, clinicians, researchers, policymakers and public health actors about, among other things, the question of what they take to be *indicators* of health. They asked for indicators, because they want the concept to be measurable. The result of these interviews and focus groups is a list of six 'health dimensions': 'bodily functions, mental functions and perception, spiritual/existential dimension, quality of life, social and societal participation, and daily functioning' (Huber *et al.* 2016, 7). The authors propose that health should be measured by examining the 'subjective experience of the quality of the six dimensions' (Huber *et al.* 2013, 58).

The conceptual relation between 'health as the ability to adapt and self-manage' and the six 'dimensions of health' seems to entail that the experienced quality of the latter tells us to what extent a person is healthy, i.e. is able to adapt and self-manage. This emphasis on the subjective perception of these dimensions of health ask for an evaluation of a whole range of aspects of life, resulting, just like the WHO although less aspirational, in a strong overlap between health and subjective wellbeing.

II. Conceptual distinctions

Now we have described the basic characteristics of five prominent concepts of health, we will discuss distinctions that reveal the ways in which these concepts differ or coincide. Although the distinctions may appear quite stringent in the table (table 2.1) , classifying the concepts is mostly a matter of emphasis or degree. Below, we discuss the distinctions in relation to those concepts in which they come most clearly to the fore.

Table 2.1: Distinctions of five health concepts

	Health as the ability to normal biological functioning (Boorse)	**Health as the (second order) ability to achieve vital goals (Nordenfelt)**	**Health as the meta-capability to achieve a set of basic capabilities (Venkatapuram)**	**Health as overall physical, mental and social well-being (WHO)**	**Health as the ability to adapt and self-manage (Huber *et al.*)**
Naturalism or normativism	Naturalism	Normativism	Normativism	Normativism	Normativism
Reductionism or holism	Reductionism	Holism	Holism	Holism	Holism
Internalism or circumstantialism	Internalism	Internalism	Circumstantialism	Internalism	Internalism
Universalism or relativism	Universalism	Relativism (cultural *and* individual)	Universalism	Universalism	Relativism
Objectivism or subjectivism	Objectivism	More subjectivism than objectivism	More objectivism than subjectivism	More objectivism than subjectivism	Subjectivism
Relation health – wellbeing	None	Health contributes to wellbeing; Wellbeing understood as desire fulfilment	Health is a necessary precondition for wellbeing; Wellbeing understood according to objective list theory	Health is identical to wellbeing; Wellbeing is undefined	Health is indicated by wellbeing; Wellbeing primarily understood in a subjective sense
Relation health – disease	Health is absence of disease	Disease reduces health	Disease reduces health	Absence of disease is minimal precondition for health	Disease and health are compatible

Naturalism vs. normativism

A central point of philosophical dispute about health concepts, regards the distinction between naturalism vs. normativism (Boorse 1975, 1997; Kingma 2010).[7] The issue at stake here is the question whether health is a purely descriptive term or whether it always involves evaluation or normative judgement. Whereas Boorse explicitly defends the idea that health is a descriptive term, as something that can be 'read off the biological facts of nature' (Boorse 1997, 4), Nordenfelt emphasises its evaluative dimension, conceptualising health as something that is – by definition – good for us. According to the latter view, judgements about health always entail assertions about what to count as vital goals, and thus assertions about what is deemed important.

It is important to note that as we will defend the view that we should understand health concepts as 'thick concepts', this denies that we can use the term in a purely descriptive way (see note 2). Nevertheless, we do think that in practices like biomedical research, the aspiration of naturalism might be deemed laudable and we thus do not discard the normativism-naturalism distinction completely.

Reductionism vs. holism

Another distinction we encountered in discussing Nordenfelt's concept in comparison to that of Boorse, was that of the *object* of health. Is health taken as a quality of the organism conceived as a collection of parts, or is health seen as a quality of a person or agent as a whole?[8] Although Nordenfelt himself frames this distinction as holism vs. atomism (Nordenfelt 1986, 281), we prefer to use the term 'reductionism' as the anti-pole of holism since the term 'atomism' may suggest that parts or part-functioning is all and everything there is to Boorse. Yet it is not the case that Boorse speaks of the 'health of a lung', but of the 'health of an organism', and it is the survival and reproduction of the *organism* that is at stake in his theory. Nordenfelt's point is rather that an organism is more than the sum of bodily parts and that we cannot *reduce* the former to the latter.

In line with the naturalism-normativism distinction, the question of whether the object of health is either the sum of bodily parts, or the organism/person as a whole, might in practice rarely be answered in favour of the former, as it is mostly assumed that health matters to a person. Nevertheless, making this distinction might be helpful for practical reflection on the question of whether the focus is actually upon parts rather than wholes.

Internalism vs. circumstantialism

The third way in which we can distinguish health concepts, we have encountered via Venkatapuram's critique on Nordenfelt. Whereas Venkatapuram embraces Nordenfelt's basic idea of health as an ability to achieve certain goals or actions, he explicitly rejects that health would be an exclusively internal affair (that is, a mental and physical condition). This is also a question about the object of health: is health a quality of the mind and the body or of the person within her circumstances? As we have already seen, according to Nordenfelt, we should not want our health concept to lead to the conclusion that a carpenter working with an arm prosthesis is equally healthy as a carpenter working with his 'own' arms. However, according to Venkatapuram, we should consider these carpenters as equally healthy. Similarly, Nordenfelt thinks that persons with equal mental and physical abilities should be considered as equally healthy, irrespective of their social and material circumstances. What matters is the 'internal' second order ability to gain the first order ability to achieve vital goals. However, Venkatapuram argues that distinguishing the health of a fit person living in Sweden from that of a fit person living in Libya, is *exactly* what a concept of health should enable us to do, since a person's health is reflected in the capabilities a person actually has in her current circumstances (Venkatapuram 2015, 8).

This blurred distinction between internal abilities and circumstances for the sake of health, is a legacy from the capability tradition. Amartya Sen, intellectual father of this approach, has developed the concept of 'capability' in order to move our attention to the practical opportunities people have and to account for the fact that the availability of goods or circumstances do not always influence people in the same way (e.g. Sen 1979, 219). Practical opportunities (capabilities) are argued to be the result of so called 'conversion factors': personal, social and environmental factors that determine the influence of resources on a person's situation.[9] According to Venkatapuram, the capability of health is thus only *partly* constituted by the second order abilities as conceived by Nordenfelt.

Regarding the question of whether health refers merely to the internal abilities of a person or also to her circumstances, Venkatapuram's position seems unique. Although the other theories do not deny the influence of the social and physical factors on health, they conceive them as 'determinants of health', rather than as 'components of health'. This might seem to be a minor difference, but it could be relevant as a circumstantial perspective helps to acknowledge the complex entanglement of a person and her material and social circumstances.

Universalism vs. relativism

Venkatapuram's concept of health deviates in a second respect from Nordenfelt's in that it denies that the content of vital goals is determined by the preferences of the individual living in a particular society. Instead, according to Venkatapuram, the content of the set of capabilities should be identical for every person. In this disagreement, we see a fourth way in which health concepts can be distinguished: the question of whether the standard or threshold of health is *relative,* that is determined in relation to a particular individual or social group, or *universal,* that is determined independent of particular individuals or groups.

As we have seen, Nordenfelt allows that the set of vital goals is determined by individual preferences and can as such differ per person. This implies that the standard of health differs from person to person. Nordenfelt argues for this by pointing out that human beings are to a great extent different from each other. Different jobs or social occupations for instance, may require different abilities (Nordenfelt 2013, 5). Moreover, according to Nordenfelt, in every society different ideas may operate about what to count as 'standard circumstances', a notion that he uses as a kind of reference class in his theory. Judgments about a person's abilities or health, are always made in reference to what is 'considered to be normal' or 'accepted' within a particular context or culture (Nordenfelt 1987, 48).[10]

Venkatapuram rejects both Nordenfelt's subjective account of vital goals, as well as this relativity of standard circumstances. He does so primarily by pointing out the relation between the two, namely that a person's preferences are strongly influenced by her material and social circumstances. As the choices we make depend on the choices we have (Venkatapuram 2011, 62-63), people in deprived circumstances are likely to have a smaller set of vital goals and/or lower standards for achievement than people who live in more privileged conditions. Moreover, Venkatapuram warns against the underestimation of the question of how a person's wants are influenced by social norms that may dominate in a particular society. As it is indicated by several wellbeing theorists, what is considered to be normal or accepted need not be desirable or good per se (cf. Nussbaum 1999). What a person within a particular culture thinks is of vital importance to her happiness may thus be compromised by the values and norms that prevail in her social surroundings.

According to Venkatapuram, a theory of health should 'specify or evaluate rights and obligations related to health', and therefore requires a universal standard of health, consisting of a specified set of capabilities that every person needs in order to live a life with human dignity. This set may be informed, but not determined, by the conditions, norms, and values of either the particular society, or the particular individual to which it is applied.

The question of whether the standard of health is universal or relative, may help to explicate the boundaries of the population a practice is oriented at: is it, for instance, the human species or the community of bearers of human rights, or is it a particular society or social group?

Subjectivism vs. objectivism

The objectivity-subjectivity distinction relates to the fifth question we would like to highlight, namely whether and to what extent the perspective of the health subject determines the health judgment. We see this especially in the elaboration of Huber *et al.*'s concept of health as the ability to adapt and self-manage. Given that the authors abstain from answering the question in what *sense*, and *to* what a person needs to adapt (Huber 2013, 53), it seems that this differs per person. This seems to be supported by the fact that Huber *et al.*

propose to give the subjective experience of individuals a central place in health evaluations (Ibid., 58). That is, the subjective perspective is crucial in judging whether a person is able to adapt and self-manage.

As said, the six dimensions of health – that is, bodily functions, mental functions and perception, the spiritual dimension, quality of life, social and societal participation, daily functioning – are argued to be evaluated by what is called 'the user' (of healthcare) herself (Huber *et al.* 2013, 53). Moreover, one reason given by Huber *et al.* (2011) for the need to replace the WHO definition, is that being diseased does not mean that a person cannot *experience* his or her life as fulfilling. So for Huber *et al.*, the subjective perspective seems to be decisive in determining the health of a person.

A remarkable difference in this regard between Huber *et al.* and Venkatapuram is that whereas the former understands adaptation to one's situation as the ultimate sign of health, the latter problematises the phenomenon of adapting one's preferences to one's living conditions. For Venkatapuram, the subjective perspective on *which* capabilities should be counted as central or basic is of no interest at all. Nevertheless, if we want to affirm the degree to which the health capability is achieved, we cannot do without the perspective of the subject herself. So, according to the idea of health as a meta-capability the subjective perspective is not irrelevant, yet it is clearly less important than in the health concept as formulated by Huber *et al*.

We thus see that the subjectivist-objectivist distinction is a question of degree, where Huber *et al*. can be situated on the subjectivist pole, and the Boorsian health concept on the objectivist pole, due to the latter's scientific approach and emphasis on objectively identifiable disease.[11] Reflection upon the question of which perspective is assigned most weight, could stimulate a moral discussion about the question of who should be considered to be the best judge of health in particular practices.

The relation between health, wellbeing and disease

A final way to distinguish these concepts, is to explicate how health is conceived in relation to two other concepts that we tend to associate with health: wellbeing and disease. For instance, as we already noted, the WHO *identifies* health with (an undetermined notion of) wellbeing, whereas Nordenfelt and Venkatapuram rather take health as instrumental to wellbeing. The WHO further states that health is *more than* absence of disease, so absence of disease is a minimal precondition for health as overall wellbeing, which probably explains the focus of WHO policies on disease prevention.

For Nordenfelt health is related to minimal happiness in the long run, whereby happiness is conceived as desire fulfilment. He emphasises in this respect that health is neither necessary, nor sufficient to be minimally happy. This is different for Venkatapuram, for whom health is a necessary condition to achieve the particular set of capabilities that constitutes a person's wellbeing. Venkatapuram thus conceives wellbeing in accordance with objective list theory. Neither of them assigns a central place to diseases in relation to health, although both acknowledge that diseases in general reduce a person's health (Nordenfelt 1986, 282; Venkatapuram 2015, 10).

The relation between health and wellbeing according to the concept of health as adaptation and self-management is rather diffuse, but it resembles the WHO's identification of health with wellbeing in the description of health as 'the capacity to cope and maintain and restore one's integrity, equilibrium and *sense of wellbeing'* (Huber *et al.* 2011, 1). According to the six indicators of health, health becomes an agglomerate of physical, mental, social, spiritual and daily wellbeing. What is most remarkable, is that for Huber *et al.* disease is almost irrelevant for the health question. That is, this concept of health is motivated by the very idea that you can still feel well even if you *do* have a disease. So, one can have cancer, and yet be healthy. What counts is whether one is able to adapt to and manage her situation, according to the subject itself.

III. Understanding 'health' as a family of thick concepts

In the first part we have aimed to show that each of the concepts makes sense in some respect, that is, they all seem to capture something that we deem relevant for understanding health. The analysis given in the second part shows that different concepts of health encompass different ideas about issues such as the proper object and perspective of health, as well as about the relation between health, wellbeing, and disease. As we will show in the last part, such issues can only be decided upon if we take into account a particular health practice. To the extent that health practices differ qua purpose and character, and different aspects of health are relevant to focus upon, we need a plurality of health concepts.

Now, the question may be raised whether it is not problematic to differentiate health practices and thereby identify different health concepts as appropriate. Are not all health practices in the end concerned with the same goal, namely health? Shouldn't we – for the sake of an integrated approach to health – adopt one single overarching concept of health that could guide them all? There are two responses to this concern. Firstly, any attempt to capture the meaning of health by one specific definition ignores the elusiveness that seems so typical to the very concept of health. We have shown that different concepts of health all capture something that seems relevant when we talk about health. Section II made clear that all these concepts differ, yet also show similarities in different aspects. In this respect, we should understand health concepts in a Wittgensteinian way: as members of a family, showing several similarities without being identical or sharing an essence. We hereby agree with Lennart Nordenfelt's statement that there is no 'Aristotelian species called "health"; what there is, is a use (or a number of related uses) of the term "health"' (Nordenfelt 1987, 11). Yet even Nordenfelt does not go far enough, as he thinks it is possible to define one common concept underlying the variety of uses of the term. A similar aspiration is expressed by Huber *et al.* who suggest that their general concept 'needs further operationalization into "definitive concepts", for use in daily practice' (Huber *et al*. 2016, 2). As we have shown, both Nordenfelt and Huber *et al.* articulate quite specific concepts of health, at least too specific to function as an umbrella term for other prominent concepts. Note that this does not imply that 'health' could mean anything: there is a point where family stops to be family. For instance, we have seen that each concept of health is either related to some notion of wellbeing, or to some notion of disease, or to both. In fact, the question of where to draw the limit is exactly something that should be subject to discussion in relation to particular health practices.

Secondly, as we will show in the last section, some health practices appear to be too diverse to let them be guided by one single concept: their different characteristics make it that different aspects of health should be focused upon. A concept of health that aims to capture all health practices risks being so broad that it may soon face the same critique as the WHO definition has had to endure, namely that it is too vague to be practicable or guiding. In fact, as the above made comparison shows: different concepts describe different conditions. At the same time, we have seen that the condition that is depicted as ‘healthy’ is at the same time valued as normal or desirable. The term ‘health’ should therefore be seen as what some philosophers have called ‘thick concepts’. Such concepts express ‘a union of fact and value’ (Williams 1986, 129), meaning that what the concept describes, is at the same time valued. As Charles Taylor explains it, thick concepts are ‘terms ...which resist splitting into 'factual' and 'evaluative' components of meaning’ (Taylor 1989, 57). Different concepts thus appear to *describe* different conditions as healthy and thus as valuable. And, what conditions are *valued*, can differ per health practice.

As we will illustrate in the next part, the above identified distinctions are answers to questions which can structure reflection on what health concept should be guiding in a particular health practice. As such, they serve as critical tools, that help us to indicate alternative viewpoints or diagnose tensions between conceptual and practical assumptions. Sometimes, the health concepts that we have at hand may appear unsatisfactory. For instance, it may be that an objectivist approach of health predominates in certain patient care-practices. If we think this is undesirable because it ignores the patient’s point of view, we may consider adopting a subjectivist concept of health like Huber *et al.*’s. Yet a wholehearted adoption of this particular concept implies the loss of other perspectives – that is, a naturalist and reductionist understanding of health. In such cases, the question should be posed what is most relevant for the particular practice under consideration: a science-based approach or the experience of the health subject? Or do we need both? What concept should be guiding in a certain practice is always a matter of emphasis or weight: we can assign more or less value to different aspects. Eventually, a practice may demand an entirely new concept.

IV. Different practices, different purposes

In this final part we briefly illustrate what it could imply to say that different health practices should be guided by different concepts of health. We do so by characterising three specific practices – biomedical research, care for chronically ill patients and health equity policies – that can be seen as practices in which either the function of cure, care, or health promotion and prevention is central. For each practice, we will discuss which health concept(s) could be considered to be the best guides for that practice.

This reflective work is a matter of looking for coherence between the aspirations of the practice, and what is described as a healthy condition by the health concept. We take it to be unavoidable that, like every reflective equilibrium, this seeking for coherence requires a moving back and forth between the practical *status quo* and the practice as it is ideally pictured.

Biomedical research

Since the second half of the 19th century, the idea of medicine as a physical science, seeking its basis in biology and physiology, has become dominant (see e.g. Ten Have 1986; Widdershoven 2000). This means that the practice of biomedical research as we know it today generally aims for knowledge of the biological causes of diseases and the effects of medical treatment on health acquired by natural scientific methods. Such research is primarily motivated by a practical wish to cure disease and illness and can therefore be understood as an instance of a cure-focused health practice.

Given its scientific character, biomedical research seems to be well served by a scientific description of health. In this respect, the BST's naturalism renders Boorse's concept a good candidate for guiding such research, as it describes health as normal biological functioning. This provides researchers with a relatively neutral and objective standard or norm to which the effects of treatment or on functioning can be compared.[12] The subjective point of view of the diseased person, or his or her wellbeing is thereby generally less relevant. Biomedical research' focus on curing disease also seems coherent with the BST's reductionism to the extent that diseases are generally conceptualised as 'located' in a certain part of the body or in partial bodily processes. We see this focus on part-functioning reflected in today's division of labour between researchers, who are often specialised in for instance dysfunctioning of the heart and arteries, immune systems, muscles or the brains.

However, notwithstanding the success stories of biomedical research, one could question whether reductionism offers the best approach to achieve insight and knowledge. For instance, the interaction between parts of the body, and between the body and its environment is at risk of being overlooked. Moreover, since the BST has been criticised for leading to controversial disease-ascriptions (e.g. Cooper 2002, Kingma 2010, Venkatapuram 2011), a more extensive debate is required to what extent Boorse's concept is actually tenable as a guiding ideal for the practice of biomedical research.

Care for chronically ill patients

In many practices of patient care, curing disease may play a central role, but in the end, the caregiving at stake is meant to make patients better off. That is, effective medical treatment can make patients feel miserable and may therefore not be worth the burden. Especially for people who will neither get well, nor die, care is essentially a matter of assisting people to cope with their illness. It thus seems that in such care-practices, the guiding health concept should picture health somehow in relation to wellbeing. Besides, there is much to say in favour of the idea that the concept should be holistic. For in order to diagnose a reported health problem and to determine the best treatment, it is important that the person is considered as a whole, including the kind of life he or she lives. The latter helps a caregiver to see in what way the health problem affects the person as an agent. In most cases of patient care, there is general agreement that it is also desirable that the patient's view on his or her own condition and, if applicable, treatment is heard and taken seriously. For this reason, it seems that the guiding health concept should be (primarily) subjectivist, thus assigning much weight to the patient's point of view.

Now, if we take this all into account, the concepts of both Nordenfelt and of Huber *et al.* could be good candidates for guiding patient care. They only differ in how they conceive of the relation between health and wellbeing, and their conceptualisation of the latter. Although Nordenfelt sees health as an important determinant of wellbeing, we also showed in section I that he makes a clear conceptual distinction between being healthy and being (minimally) happy. This might be an advantage if one wants to distinguish the task of the caregiver from being concerned with people's health, from being concerned with their happiness. Sometimes this distinction may not be so relevant, such as in intramural care. Here the concept of Huber *et al.* might be of better use, as it takes the experienced quality of the six 'health dimensions' as indicators of health.

Public policies concerned with health inequities

Inequality in health levels is an important concern for public health practitioners, whose primary job it is to promote the health of a population, be it regional, national or global (e.g. Mackenbach and Stronks 2004). To the extent that public health policies promote health for the sake of people's wellbeing, it seems to make sense to say that the health concept we seek is normative, holistic, and relates to wellbeing, such that citizens are respected as persons for whom health matters.[13]

The very idea of 'inequality of health levels' implies that health is conceptualised as something which is measurable. Note that this does not demand that health is understood in an objectivist sense: a whole scale of health questionnaires exists that ask for the subjective perspective of individuals. The question is whether the questionnaires used, give results that make meaningful comparison possible. Moreover, to the extent that justice is the main reason to be concerned with health inequalities, it seems preferable that policies are not guided by a radically relativistic concept. The formal idea of justice that equal cases deserve equal treatment, at least seems to demand that the same measure is used for each individual. Further discussion is required on the question whether this health measure should be universal, that is, independent of particular individual or societal norms or values, or that it may be relative to the norms of a particular society. Answering this question will further depend both on whether it concerns national or international policies and on the particular concept of justice adopted. A last relevant consideration is whether the health concept should be ‘circumstantialist’, as Venkatapuram proposes. In order to promote public health, a focus on health determinants, like a safe environment and access to healthcare, is of particular interest. Including them in the concept of health may ‘force’ policymakers to recognise their importance better than when they are excluded. On the other hand, we could wonder whether this circumstantial view does not lead us too far from a common sense understanding of health.

Conclusion

In this chapter we have argued that, rather than seeking one ‘overall’ conceptual theory of health that applies to all contexts, it makes sense to take different health concepts as appropriate for guiding different practices. We argued for this by showing that each concept of health that we discussed seems to capture a relevant aspect of health, and that deciding about which aspects are relevant, depends on a particular health practice. We have argued that there is no reason to seek for one single concept of health, since analysis of the discussed concepts does not reveal a shared, essential meaning. Moreover, besides from this understanding of health concepts as members of a Wittgensteinian family, they are to be understood as ‘thick concepts’, that describe a condition which is at the same time valued. This evaluative dimension of health concepts enforces the idea that different practices may demand different concepts, as different aspects are valued and/or focused upon. Ideally, there is a strong coherence between the nature and purposes of health practices and the conceptual features and evaluative dimensions of the guiding health concept. At the same time, the availability of alternative health concepts (and an understanding of how they differ) may guide critical reflection on the assumptions and purposes of health practices. The here provided overview of concepts and their distinctions is meant as a toolkit for such conceptual and normative reflection, which can be extended and refined as a result of such reflection.

Notes

1. Other concepts are, for instance, "health as flexibility and adaptation" (Canguilhem, 1989), "health as being in harmony with one's environment" (Gadamer 1996). More recently, P. A. Tengland (2007) proposed a two-dimensional theory of health that can be seen as an adaptation of Nordenfelt's theory, both a refinement (adding health related well-being) and a simplification (omitting the second-order requirement and omitting "vital goals").

2. The central point of this critique, one we endorse, is that the very idea of statistically normal biological functioning presupposes notions that are not neutral but result from what we consider to be "normal," such as the formulation of "survival" and "reproduction" as biological goals, or "sex" and "age" as reference classes.

3. For the moment, we leave undiscussed the additional criterion of "standard" or "acceptable/reasonable circumstances." This criterion generally says that judgments about p's health have to take into account the circumstances in which p finds her/himself. See for discussions on this Venkatapuram (2013), Nordenfelt (2013), and Tengland (2016).

4. See Tengland (2007) for a critical discussion of whether Nordenfelt succeeds in meeting this "ordinary language" criterion.

5. Note that, according to Nordenfelt, "disability" is a matter of ill-health, which may be regarded as counterintuitive.

6. See Boorse (1975, 60); Larson (1999, 128); and Smith (2008).

7. This distinction between naturalism and normativism is sometimes referred to as that of "naturalism vs. constructivism," or as "objectivism vs. constructivism" (Murphy, 2015). As Murphy points out, concepts of health (and disease) cannot always be strictly divided according to this distinction,

for most theorists acknowledge both their biological as well as their societal dimensions.

8. Tengland argues that holistic theories “take the whole, acting and experiencing individual as their starting point, and that, in general, they also define health in relation to a context, that is a social and physical environment” (2016, 9). However, we think that the relation between the individual and her environment deserves a separate discussion (see “internalism vs. circumstantialism”).

9. Conversion factors as identified by Venkatapuram are “individual endowments, conversion skills, extant physical conditions, and surrounding social conditions” (Venkatapuram, 2011, 155).

10. See, for a more elaborate discussion on this and the distinction between “standard” and “reasonable” circumstances, Venkatapuram (2013) and Nordenfelt (2013).

11. For the moment, we ignore the distinction between disease and illness (e.g., Boorse, 1975).

12. Given the strong connection of biomedical research with the practice of medical treatment, it can be questioned how well the scientific pretention of neutrality and objectivity are lived up to, but that does not mean that scientific objectivity is a valuable aspiration in itself (thanks to an anonymous reviewer for pointing this out).

13. It is remarkable that contrary to these considerations, Norman Daniels (2008) takes the reductionist and naturalist concept of health—the BST—as a basis for his theory on just health and health needs.

Chapter 3

Do conceptualisations of health differ across social strata? A concept mapping study among lay people

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Chapter 3 Do conceptualisations of health differ across social strata? A concept mapping study among lay people

Introduction

There is considerable evidence for socio-economic inequalities in health within countries, to the disadvantage of people in lower socio-economic groups (Jagger et al. 2011; Mackenbach et al. 2008; Mäki et al. 2013). However, less research has focused on how people from different social strata *conceptualise* health. From a policy perspective, this is an important issue: the legitimacy of policies that aim at improving the health of people in lower socio-economic groups can be challenged if these policies do not reflect the conceptualisations of health that are valued in all strata. For instance, if policies tacking health inequalities primarily aim at closing the gap in mortality, while people subjected to those policies understand health primarily as 'health-related quality of life', it is questionable whether the policy-focus on mortality has sufficient public support.

Health is a so-called 'thick concept', i.e. its meaning has both descriptive and evaluative dimensions, in the sense that 'health' describes a condition which is at the same time valued (chapter 2). Given its evaluative dimension, the way people conceptualise health may differ between socio-economic groups, to the extent that different socio-economic groups are disposed to different practices (e.g. value eating three meals a day or not), which in turn may be shaped by differences in living conditions (e.g. availability of time and money to spend on dining) (Burgard & Chen 2014; Burnett & Veenstra 2017). Indeed, the few studies that investigated how health is conceptualised across social strata indicate relevant differences. For example, d'Houtaud & Field (1984) show that, in the lower socio-economic groups, respondents emphasised health as the absence of sickness, whereas in higher socio-economic groups health tended to be defined in terms of vitality. The latter finding was confirmed in a study by Peersman et al. (2012), in which people were asked what conceptualisation of health they had in mind when answering the well-known single-item question on self-rated health.

However, knowledge in this field is limited regarding both the number of studies performed and the context in which they were performed as well as the methodology used. Therefore, this study aims to contribute to this body of knowledge by analysing how different socio-economic groups formulate their own answers to the question: What does health mean to you?

I. Methods

We used the methodology of concept mapping, which is a structured process to explore the conceptual ideas of a group about a complex multi-dimensional topic. The outcome is a concept map, i.e. a visual representation of the group's thinking summarising all their ideas. Concept mapping is a suitable methodology for our research question given that: a) the study subject is complex, i.e. the concept encompasses many different aspects and not all of those aspects, or the relationships between them, are clear; b) there are different perspectives on a given subject, informed by different norms and values (Trochim 1989.

For this study, the concept mapping approach described by Trochim was used, involving six steps: 1) preparation; 2) generation of statements; 3) structuring of statements; 4) representation of statements in concept maps; 5) interpretation, and 6) utilisation (Kane & Trochim 2006; Trochim 1989). Here we report on steps 1-5.

Step 1: preparation

The study was performed in the western area of the city of Utrecht, that has various neighbourhoods largely representing the extent of the socio-economic ladder. Participants were invited via leaflets distributed through letterbox drops, and handed out in local supermarkets, health care centres, and community centres.

Socio-economic status (SES) was indicated by *educational level*. People who responded positively were asked about their highest educational level attained. Then, three groups were distinguished based on the highest level of education attained: 1) higher: college degree up to academic degree; 2) intermediate: secondary school (intermediate and highest level) up to secondary vocational degree; 3) lower: no education up to secondary school (lowest level).

Step 2: generation of statements

One concept mapping session was arranged for each educational group (in Spring 2015); these sessions lasted about 4 h each. Each of the sessions provided information on: the study aim/background, the usual rules for brainstorming, and the focus of the concept mapping procedure. Audio-recordings of the sessions were made to enable confirmation of the statements and editing. We chose to formulate the brainstorm focus prompt as follows: '*Health means to me...*', indicating that we were seeking a person's *own* thoughts and ideas. During the sessions, statements were uniquely numbered, entered into a computer, and displayed on a large screen; this allowed all participants to see the set of statements as they evolved. Double or overlapping statements were deleted during the sessions, in consultation with the participants.

After collecting the statements from each participant, the moderator asked the group to come up with statements that had not been mentioned before. The moderator also mentioned aspects of health emerging from earlier studies in Netherlands on health (Kooiker 2010; Huber et al. 2011), in case they had not been mentioned by the participants. This was the case for a maximum of three statements only. If there was at least one participant who recognised the additionally mentioned aspect as important, it was added to the list (after it had been reformulated into a statement by the group as a whole). The list was considered to be complete when no new statements were generated.

Step 3: structuring of statements

For the structuring process, each generated statement was uniquely numbered and printed on a separate index card. Each participant received two complete sets of cards. For the first structuring task, i.e. the sorting, each participant individually grouped the cards of one set into piles that associatively 'belong together in a way that makes sense to you', and labelled these piles, based on their content. Participants were not limited in the number of piles they formed, nor in the number of statements in each pile. For the second task, i.e. the rating, the participants were asked to rate each statement on a 5-point Likert-type response scale, ranging from 1 (least important) to 5 (most important), by dividing the index cards into five equal piles of increasing importance for understanding what health is.

Step 4: representation of statements in concept maps

After the meetings, the statements of each group and the individual structuring data were entered in the software program 'Concept System Global Max'. Using two-dimensional nonmetric multidimensional scaling of the similarity matrix of the aggregated sorted data, the software produces a two-dimensional plot of the statements (Kane & Trochim 2006; Trochim 1989). With regard to the content, the greater the distance between two statements (dots on the pointmap), the weaker the statements are associated with each other. The software then uses the coordinates of the statements on the map as input for a cluster analysis. Anticipating step 5, i.e. interpretation, the software enables for manually inspecting the different cluster solutions and proposes labels for each cluster, based on the participants' labels.

Step 5: interpretation

The interpretation step was done by nine researchers involved in the project, during two meetings. Within this group, it was discussed and decided which cluster solution made most sense, given the content of the statements within the clusters. For each educational group, we started with a map representing 14 clusters and labelled these clusters based on their content (i.e. statements within the clusters) and suggested labels by the participants, as given by the software. Using a cluster tree, we interpreted every reduction in the number of clusters. A reduction implied that statements of two clusters were merged into one new cluster. We assessed whether this new cluster summarised the data in a meaningful way without losing important distinctions as expressed in the statements. If so, the new cluster was labelled based on its content. As soon as a further merge led to a loss of meaningful distinctions, the optimal number of clusters was achieved.

Occasionally, we also used Bridging Values. This value indicates whether the statement was sorted with others that are close to it on the map (low value) or whether it was sorted with items that are further away on the map (high value). In a few cases, based on these values as well as an in-depth analysis of the content of the statements, we redraw the borders of clusters to make these clusters better to interpret. Consensus was reached by discussion, in an iterative process. To promote an open discussion and preclude bias, we purposely searched for diversity in the group, regarding previous experience with the concept mapping technique, disciplinary background (public health, philosophy, social sciences), and working environment (academic setting, non-academic research, public health policy and public health practice). After consensus was reached on the clusters in each group, the researchers compared each of the clusters within one group with a similar cluster found in the two other groups. A comparison was made regarding differences and commonalities in order to ensure that similar cluster-interpretations were made for the different educational groups.

The final step was to compare the three concept maps on similarities and differences. The group compared the type of clusters, the wording of the labels of the clusters and statements within the clusters, and the ranking of the clusters and statements. These comparisons were based on a face-value analysis. Consensus was reached by discussion.

Ethical approval

The study was judged to need no further review by a local ethic committee because the Medical Research Involving Human Subjects Act (WMO) does not apply to our concept-mapping study: participants were recruited on a volunteer basis and were not required to undergo physical examination. We obtained written informed consent from all participants.

II. Results

Participants in steps 1 to 3

A total of 46 persons participated: 16 in both the higher and intermediate education group, and 14 in the lower education group (table 3.1). Eight people did not participate in step 2 (generation of statements) but did rank and sort the statements (step 3) that were generated during the session of the educational group they belonged to. They performed this task at home, with two piles of cards and clear instructions. The age distribution of the groups differed, i.e. the lower educated group were older than the other two groups. In all three groups, the majority of participants was female.

Table 3.1: Characteristics of the three groups, by educational level

Education group	N (step 3 only)	Educational level	Mean age (years)	Percentage of women
Higher educational level	16 (5)	15 high /1 intermediate	44	75
Intermediate educational level	16 (2)	13 intermediate / 3 high	49	56
Lower educational level	14 (1)	14 low	69	79

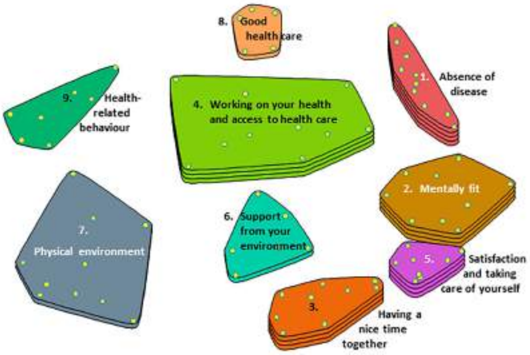
Three concept maps: content of statements, and clusters

The number of statements generated ranged from 74 in the lower and higher educational group, to 87 in the intermediate education group. The three concept maps are presented in figure 3.1. The concept maps for the lower, intermediate and higher educational group consist of nine, eight and seven clusters, respectively. Each cluster represents 5-17 statements, indicated by dots in figure 3.1.

Figure 3.1: Concept maps for three educational groups, showing the statements, grouped into clusters; the smaller the distance between two statements or clusters, the stronger they are associated with each other; a higher number of layers indicates an increasing importance of that cluster for understanding what health is.

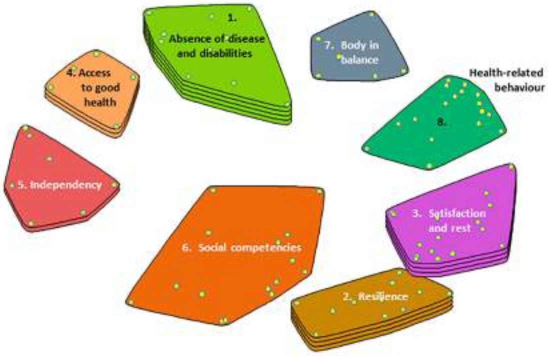
1a Lower educational group

Number of layers	Average rating of all statements within a cluster
1	2.74 to 2.88
2	2.88 to 3.02
3	3.02 to 3.17
4	3.17 to 3.31
5	3.31 to 3.45



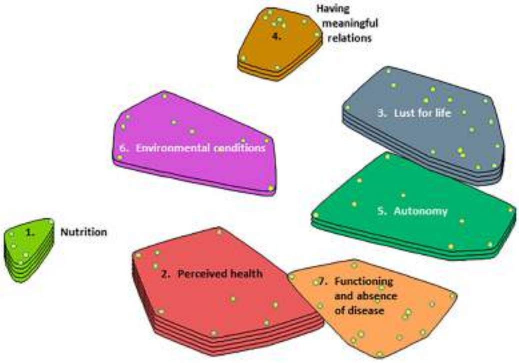
1b Intermediate educational group

Number of layers	Average rating of all statements within a cluster
1	2.85 to 3.03
2	3.03 to 3.21
3	3.21 to 3.39
4	3.39 to 3.57
5	3.57 to 3.75



1c Higher educational group

Number of layers	Average rating of all statements within a cluster
1	2.96 to 3.07
2	3.07 to 3.19
3	3.19 to 3.31
4	3.31 to 3.43
5	3.43 to 3.55



Description of the concept maps

All groups identified a cluster related to the *absence of disease and disabilities* with statements referring to disease, pain, discomfort, disabilities, and functional abilities (table 3.2). In the lower educational group, emphasis was on the absence of disease or physical complaints, whereas in the intermediate and (to a lesser extent) the higher educational group, most statements reflected aspects of functional abilities (e.g. being physically able to do what one wants). Furthermore, in the higher educational group, items on self-perceived health (e.g. being vital) are also included in this cluster, besides a separate cluster on ‘perceived health’, which is located close to the cluster on functioning and absence of disease (figure 3.1). Perceived health as a cluster was absent in the other groups.

Clusters related to *health-related behaviour* were present in all groups. In the intermediate education group, the cluster contains a wide range of behaviours. Additionally, in this group, also the cluster ‘body in balance’ consists of health-related behaviours, in particular in relation to their impact on health (e.g. having a good sleep). In the higher educational group and (to a lesser extent) in the lower education group, the health-related behaviour cluster is restricted to nutrition. In the higher education group, statements on other health-related behaviours were grouped in the cluster ‘perceived health’, located next to the nutrition cluster (figure 3.1). This suggests that these items were interpreted in terms of their impact on physical and mental health. In the lower educational group, other aspects of health-related behaviour were combined with statements on having access to good health care in one cluster ‘access to health care’, which was located next to the health-behaviour cluster (figure 3.1). This seems to indicate that statements on health-related behaviour were largely seen as ‘having opportunities’ to behave in a healthy way. In addition, the concept map of the lower educational group holds another cluster on health care, namely ‘good care’ with statements such as ‘getting attention from your doctor’ and ‘getting equal treatment’. A similar cluster was found in the intermediate education group, although that cluster also concerns access to goods other than health *care* (e.g. access to green space) and is therefore labelled as ‘access to health’. The higher education group had no cluster on health care.

Furthermore, all groups also conceptualised health in terms of having a satisfactory *social life*. In the low and intermediate education group the emphasis was on having a nice time together, whereas in the higher educational group the focus was on having meaningful relationships.

Clusters related to *physical environment* contain statements that refer to a healthy house, workplace and environment. The intermediate education group does not have a cluster on physical environment. Their statements related to physical environment are part of other clusters (i.e. body in balance, and access to health).

In all educational groups, also one's *attitude towards life* was considered to be an aspect of health. The higher education group clustered statements as having lust for life, being able to enjoy, accept yourself, being able to be independent, and being able to cope. The intermediate education group grouped this type of statement into two clusters which were located next to each other, namely 'resilience' and 'satisfaction and rest' (figure 3.1). The same applies to the lower educational level, where the two closely-related clusters referred to 'mental fitness' and 'satisfaction and taking care of yourself' (figure 3.1). In the latter group, the wording of many of the statements focuses on satisfaction and acceptance of life: for example 'relaxation', and 'being comfortable in your skin'.

In addition, the concept maps of the higher and intermediate educational groups hold a cluster on *autonomy and independence*. In the intermediate education group this includes statements such as 'being mentally clear', and 'being independent from the help of others'. The higher educational group mentioned 'being independent', and 'making one's own decisions'.

Table 3.2: Description of the clusters for the three educational groups

Higher education	Intermediate education	Lower education
Absence of disease and functioning		
• Functioning and absence of disease	• Absence of disease and disabilities	• Absence of disease
Perceived health		
• Perceived health	(none)	(none)
Health-related behaviour		
• Nutrition	• Health-related behaviour • Body in balance	• Health-related behaviour • Working on your health and access to health care
Access to health care		
(none)	• Access to health	• Good health care
Social life		
• Having meaningful relations	• Social competencies	• Having a nice time together • Support from your environment
Attitude towards life		
• Lust for life	• Resilience • Satisfaction and rest	• Mentally fit • Satisfaction, and taking care of yourself
Autonomy and independence		
• Autonomy	• Independency	(none)

Ranking of clusters and statements

The clusters were ranked, based on the average rating of all statements within a cluster. The layers in figure 3.1 indicate the average rating. The relative ranking of the clusters differs between the groups (table 3.3), with the pattern for the higher educational group being the most distinct. Whereas 'absence of disease' is ranked highest in the intermediate/lower education groups, the group with high education ranked this aspect lowest. The pattern was reversed for clusters on health-related behaviour. Similarities between the groups include the relatively high ranking of the clusters on attitude towards life, and the ranking of the satisfactory social life in the middle.

In all groups, mental health is ranked as the single most important statement (table 3.3). Notable is that, also in the group with the higher educational level, the five statements that are ranked highest express 'positive' states (e.g. lust for life), whereas the group with the lower/intermediate educational level formulate two and one, respectively, of the five highest ranked statements in a negative manner (e.g. having no stress).

Table 3.3: Ranking of the clusters and statements in the three educational groups

Education:	Higher	Intermediate	Lower
Ranking of the clusters			
1 (highest)	Nutrition	Absence of disease and disabilities	Absence of disease
2	Perceived health	Resilience	Mentally fit
3	Lust for life	Satisfaction and rest	Having a nice time together
4	Having meaningful relationships	Access to good health	Working on your health and access to health care
5	Autonomy	Independency	Satisfaction and taking care of yourself
6	Environmental conditions	Social competencies	Support from your environment
7	Functioning and absence of disease	Body in balance	Physical environment
8		Health-related behaviour	Good health care
9 (lowest)			Health-related behaviour
Ranking of the statements: five highest ranked			
1 (highest)	Feel physically and mentally well	Being mentally clear	Being mentally healthy
2	Having lust for life	Mental rest	Having no stress
3	Being able to enjoy	Being able to enjoy	Having no chronic disease
4	Being able to be independent	Having sufficient energy	Getting attention from your doctor
5 (lowest)	Sufficient exercise	Having no pain	Having sufficient money for healthy food

IV. Discussion

In all three groups health was conceptualised as a multidimensional concept. Four clusters occurred in all groups, i.e. absence of disease and functioning, health-related behaviours, social life, and attitude towards life. Differences were also observed. First, some dimensions appeared to be specific for particular educational groups: e.g. access to good health care was specific for the lower/intermediate education group, autonomy or independence for the intermediate/higher education group, and perceived health for the higher education group. Second, the content of some clusters differed. The cluster 'absence of disease' was literally used in the lower education group but was broadened to 'functioning' in the intermediate education group, and further broadened to 'self-perceived health' in the higher education group. Social life was conceptualised in the lower education group in terms of 'having a nice time together' to 'having meaningful relationships' in the higher education group. 'Attitude towards life' in the higher educational group suggests 'lust for life' and shifted to an emphasis on satisfaction and acceptance of life in the lower education group. Finally, differences were observed in ranking: the clusters that relate to health behaviour were ranked highest in the higher education group, and lowest in the other groups, whereas the ranking was reversed for the absence of disease dimension. In addition, positive aspects were ranked higher in the higher education group, versus negative aspects in the lower education group.

Interpretation of similarities

The finding that all socio-economic groups consider health as a multidimensional concept was also reported by Simon et al. (2005). They investigated what Dutch people with different levels of education took into consideration when answering a question on self-rated health. Both their findings and ours are in contrast to the results of Calnan & Johnson (1985) whose lower-class group saw health as one-dimensional, in terms of 'getting through the day' and 'never being ill', whereas the higher-class group mentioned also other dimensions as indicated by terms such as 'feeling strong' and 'being active'. This difference between the outcome of Calnan & Johnson's and our study might be explained by the fact that the participants in their study were asked in the abstract about health, in the setting of a personal interview. The lower-class group might have been less used to give their abstract views and therefore might have come up with single dimensions only. Mentioning multiple dimensions might have been much easier for the respondents in our study, who met in a group setting, and were explicitly asked to generate multiple statements.

All our socio-economic groups conceived health in both subjective and objective terms. ‘Feeling happy’, ‘feeling good’ or ‘accepting your handicap’ are examples of subjective dimensions, in which the perspective of the individual determines the health judgement. Examples of objective dimensions, i.e. defined by an external criterion, include ‘having no chronic condition’ and ‘no smoking’.

Interpretation of differences

However, differences were also observed. First, the lower/intermediate education groups were more inclined to define health negatively, as ‘not having a disease’, i.e. as an absence of health threats. The highest education group predominantly preferred positive framing. This might reflect actual differences in health between socio-economic groups, with people in lower socio-economic groups having a much higher risk of suffering from a health problem themselves or having people in their environment that suffer from health problems. Thus the actual circumstances in which people live are important for how they conceptualise an abstract notion such as health.

Second, the conditions that were mentioned as essential for *having access to good health* differed between the socio-economic groups. Whereas the higher/intermediate education group referred (in five of seven and six of eight clusters respectively) to the quality of the body or mind (e.g. body in balance), the lower education group framed these in terms of a person within his/her circumstances (six of the nine clusters). The top five of highest ranked statements showed a similar pattern. A similar result was reported by d’Houtaud & Field (1984) where conditions such as ‘medical supervision’ were more often mentioned in the lower socioeconomic groups. Also, in the present study, the way in which similar items were formulated in different socio-economic groups seems to support this distinction. For example, the cluster in the lower education group with the heading 'support from your environment' is mirrored in the qualification of 'autonomy' and 'being able to care for yourself' as an asset of the individual in the higher education and intermediate education group, respectively.

Third, also the *value* of being in good health seems to differ between groups (cf. Lawton 2003). In accordance with studies by d'Houtaud & Field (1984) and Calnan & Johnson (1985), the highest socio-economic group was more inclined to perceive health in terms of what d'Houtaud & Field called 'hedonistic use of life', such as 'good mental equilibrium'. In our study, examples include the cluster 'lust for life', in which statements referred to the meaning of life, grip of life and vitality. In contrast, in the lowest socio-economic group the conception of health corresponded with more 'functional' notions of health, in terms of 'getting through the day' and 'being able to work' (cf. Calnan & Johnson 1985).

Finally, some statements seem to reflect a different attitude, from a more active attitude on life in the highest socio-economic group to more acceptance of life and what it brings, in the intermediate/lower education group. An example of the latter includes a statement such as 'having fun together'. An example of the former includes 'having lust for life'. This is probably a reflection of the differences in socio-economic circumstances that the groups face (Lawton 2003). The more difficult the circumstances, the more common it may be to see health as something that should be 'just good enough' to face challenges.

Methodological limitations

There are several advantages of concept mapping compared with (semi-structured) interviews to lay views on health. There is, for instance, no question-answer structure, except from the open prompt that participants had to complete. This brainstorm setting ensures minimal intervention from the moderator, allowing the vocabulary of the participants to remain largely intact. Whereas in focus groups the more dominant voices might steer the discussion in a particular direction, in concept mapping this dynamic is restricted by the initial individual brainstorm, the brainstorming rules, and the individual structuring process. This individual input ensures that the perspective of each participant is equally reflected in the final concept map.

However, as with focus groups, the result of a concept mapping study is the perspective of a particular group, raising the question of external validity. This is important because the groups in the present study may not be representative for the various educational groups in the Netherlands, given the small number of participants, their regional origin, the sex distribution, and the selection method used. A more fully saturated concept to increase external validity might be achieved by repeating the same procedure several times, in different areas, and with different groups (Bon-Martens et al. 2017). Furthermore, in a concept mapping study, the possibility to examine what is meant by a certain statement or expression by the participants is relatively limited. In our study, this was particularly so as we decided *not* to involve the participants in the representation and interpretation stage, mainly for practical reasons. As a consequence, we as researchers felt a certain level of uncertainty as to the exact interpretation of the different clusters, in view of, e.g. the different type of statements that clustered together. However, as discussed in the method section, we strived for diversity in the group of researchers to promote an open discussion and preclude bias. In addition, the advantage of the fact that we as researchers have carried out the interpretation stage, is the comparability of the maps across education groups. Moreover, the broad conceptualisation of health, with various clusters is confirmed in other studies. This includes a study by Huber et al. (2011) on indicators for a new, dynamic concept of health, as well as a study using the same methodology as ours, but performed in five other Dutch cities (Flinterman et al. unpublished). In addition, the clusters and the distinctions that we identified in the interpretation of the results as well as the differences between socio-economic groups therein, corroborate those identified earlier (e.g. Calnan & Johnson 1985; d'Houtaud & Field 1984; Hughner & Kleine 2004). A third weakness in our study concerns the differences in age between the three groups. The fact that the lowest educational group was on average 20 years older than the other groups raises the question whether the differences in the final concept maps could actually be attributed to differences in age rather than in socio-economic status. We consider this not to be very likely, however. Although Simon et al. (2005) showed that older people more often had a multi-dimensional concept of health compared to younger people, the study of Peersman et al. (2012), in which both age and educational differences have been analysed, indicates only small differences in the way people of different age groups conceptualise health. Furthermore, as discussed above, our findings correspond with the results of previous studies. Finally, we observed similarities between the lower and intermediate socio-economic groups, such as the inclination to define health negatively, despite substantial age differences between these group.

A fourth weakness that needs to be discussed concerns the choice for educational level as an indicator of socio-economic status. In studies on health inequalities, education is a frequently used indicator of adult socio-economic status (d'Errico et al. 2017). It is strongly associated with occupational level and income, but has the advantage of being available for each individual, also, e.g., for those without a paid job. Although different indicators might indicate different aspects of someone's position (d'Errico et al. 2017), we do not expect our results to be biased by the choice for this indicator, as the conceptualisation of the concept mapping groups not only reflect aspects closely related to educational level (such as autonomy), but also aspects related to income and occupational level (e.g. having access to health care or living in a healthy environment).

Implications

If confirmed in future studies, our results could be used to critically consider the legitimacy of policies aimed at tackling health inequalities. We give three examples, to illustrate the type of implications that we foresee. First, given that health has been conceptualised as a multidimensional phenomenon in all groups, it might be argued that health policy goals need to cover a broad spectrum of health aspects, ranging from, e.g., chronic conditions to self-perceived health to vitality. Second, the concept maps of lower socio-economic groups in particular support health policy goals that also include the conditions that shape health, as in the case in the WHO social determinants of health approach. Third, the differences between socioeconomic groups in the way health is conceptualised, challenge the legitimacy of policies that are based on a notion of health that resonates the conceptions that are valued in higher socio-economic groups in particular, such as ‘good mental equilibrium’ or ‘lust for life’.

Conclusion

The conceptualisation of health, although multidimensional in all socio-economic groups, showed differences between these groups. In our study, people in lower socio-economic groups were more likely to show a conceptualisation of health that refers to: 1) the absence of health threats (*versus* positive aspects), 2) a person within his/her circumstances (*versus* quality of own body/mind), 3) the value of functional (*versus* hedonistic) notions, and 4) an accepting (*versus* more active) attitude toward life and what it brings.

Chapter 4

From health to justice. The relevance of studying health concepts for justice

Chapter 4 From health to justice. The relevance of studying health concepts for justice

Introduction

Considering the previous chapters, the meaning of health appears to be elusive, as the ways in which it is conceptualised vary considerably among both theorists and ordinary citizens. At the same time, in daily speech we all seem to know what we mean when we talk about health, and we also have all kinds of widely accepted measures of which we say that they indicate how healthy people are. It thus seems that it is only when we try to pin down the meaning of health that we create problems, rather than solve them. Therefore, one might still question whether studying the meaning of health isn't a typical example of philosophical pastime that has not much relevance for real world problems.

The former chapters argued – to the contrary – that we *should* be concerned with the meaning of health because how we understand health has normative implications. Still, it may not be entirely clear what exactly these normative implications are for our concern with (measuring) socioeconomic inequalities in health. Thus far, this question has only been provisionally answered: chapter 2 proposed that theories of health help us see that deliberate reflection upon what we understand by health is important because of the evaluative dimension of the term: when we call a person healthy, we implicitly express what we value. And that therefore, some aspects of health may be more relevant for a practice like health equity policies. Chapter 3 suggested that – because of this evaluative dimension – discrepancies between conceptualisations of health by 'lay' persons and concepts of health that prevail in public policies may challenge policy legitimacy.

In this chapter, I examine these suggestions of the two conceptual studies further, thereby considering them in the light of the question of what health inequalities we should focus upon when concerned with justice. While considerations of justice will be central in the next chapters, I take justice here as having to do with what is sometimes called the formal principle of equality, i.e. that like cases should be treated equally and unlike cases unequally proportionally to their differences, and that this moral principle requires an impartial point of view (e.g. Gosepath 2007). In addition, in relation to the concept map study, I briefly discuss 'participatory parity' as a concern of justice, as it ensures recognition of marginalised groups.

The first section discusses the question of which health aspects as distinguished in the theoretical study should guide a moral concern with socioeconomic health inequalities. Considered in the light of the concerns of impartiality and equal treatment, it may seem that health inequalities should be understood in an objective and universal sense. I show that this conclusion might be too quick and that we have good reasons not to dismiss subjective health measures, as well as to be critical about applying universal health standards and be open for some relativism in health standards. The second section continues the discussion about universal vs. relative standards of health by addressing the questions of why citizens' views on health should be taken into account for health equity policies, and to what extent the concept map study reveals adaptive preferences, which would be reason to dismiss relative standards.

Theoretical concepts of health: which aspects deserve our focus?

Chapter 2 argued that we have no reason to seek one single concept of health, as different practices and contexts may be guided by different health concepts. This was made plausible by showing that different health concepts could be interpreted as members of a conceptual family, given that the discussed concepts do not reveal one shared, essential meaning. Moreover, it was suggested that health concepts are to be understood as 'thick concepts': i.e. they have a descriptive and evaluative dimension in the sense that they describe a condition which is at the same time valued. By analysing the philosophical debate about different concepts, several distinctions came to the fore regarding e.g. the object or perspective of health. Thus conceived, different health concepts highlight different aspects of health. We have proposed that these distinctions may help us structure reflection on what understanding of health should guide particular practices or policies.

Regarding the policies concerned with health inequalities for reasons of justice – i.e. health equity policies – I argued that it seems plausible to say that the guiding concept of health should be *holistic* and be somehow *related to wellbeing*. Moreover, we have said that it remains an open question to what extent the concept should privilege an *objective or subjective* perspective, whether it should propagate a *universal or relative* standard, and whether it is of any help to take health as a quality of the individual *within,* or *without her circumstances*. Elsewhere, I have further emphasised that deciding on these last three issues requires additional practical and normative considerations (Haverkamp et al. 2017). It is the aim of this chapter to examine some of these considerations further. I will thereby focus on two questions. Firstly, should health equity policies be primarily concerned with subjective or objective health judgements? Secondly, should health be seen as a universal or as a relative standard?[1] A discussion of these questions allows me to scrutinise the idea that theories of justice should be concerned with objective and universal measures of inequality, as is often argued by e.g. capability theorists.

Impartiality and the question of subjective or objective perspectives

Considering theories of justice, it may appear that inequalities in health expressed in subjective terms, i.e. health as judged by people themselves, such as with the health measure of 'self-rated health', are of little relevance. Daniels (2008; see chapter 6) argues for instance that when we are concerned with health justice, we should conceptualise health in an objective way, such that we can objectively determine what people's health needs are. Likewise, capability theorists have emphasised the importance of a focus on an objective understanding of wellbeing. The view that an objective understanding of wellbeing should be central coheres with the idea that justice requires an impartial point of view. How should we relate this to the question of whether the subjective or objective perspective should be privileged in measuring and addressing health inequalities?

One argument not to use subjective notions of wellbeing is that people's self-evaluations, i.e. 'self-perceived health', would ignore the (objective) physical health condition. Sen refers to this as 'physical condition neglect'. When problematizing welfare conceptions that look at people's mental attitudes, such as 'happiness', and 'desire-fulfilment', Sen argues:

> *'A person who is ill-fed, undernourished, unsheltered and ill, can still be high up in the scale of happiness or desire-fulfilment if he or she has learned to have 'realistic' desires and to take pleasure in small mercies. The physical conditions of a person do not enter the view of well-being seen entirely in terms of happiness or desire fulfilment.* (Sen 1985, 21)

So, if different persons answer the question 'how do you judge your own health?' with 'good', Sen's notion of physical condition neglect warns us that this may not correspond to objectively observable health conditions, for instance because people differ in their pain barriers.

The question is thus whether equal outcomes in subjective health measures, ignore inequalities in 'objective' mental and physical health conditions. This does not seem to be the case in practice: in answering the commonly used self-rated health measure 'How do you judge your health in general?' it is found that people take into account (at least) four different aspects of health: physical conditions, functional abilities, mental attitudes, and feelings (Simon 2002; Simon et al. 2005). This shows that the self-rated health measure does not suffer from *entire* 'physical condition neglect'. But this general measure does not *specify* physical conditions in terms of e.g. diseases and impairments, and self-diagnosis may thus not be trustworthy. An adequate concern with inequalities in physical health conditions therefore also requires objective measurements to avoid physical condition neglect. Therefore, relying *merely* on subjective health measures would indeed be problematic, if we think – as I do – that objectively ascribable health conditions have normative relevance.

However, we need not reject subjective health measures altogether. In fact, we may have good reasons to look at *both* inequalities in subjective and objective health measures. One reason to complement objective with subjective health measures, such as life expectancy in perceived good health, is that they take into account aspects of health that cannot be measured otherwise. As Simon (2002) shows, besides objectively measurable states such as diseases and functional abilities, people also refer to feelings when evaluating their own health. And feeling energetic, tired, or being in pain are inherently subjective affairs. In this sense, subjective health measures add something to objective measures. Importantly, ignoring perceived health would be at odds with a widely shared view that feelings are an important aspect of health. For instance, our concept map study showed that all groups included feelings – such as 'having lust for life', 'having no pain', 'having no stress' – among the five highest rated aspects of health. Also, Tengland – who defends a concept of health that is a refinement of Nordenfelt's theory – argues that 'positive moods and sensations' (Tengland 2007, 257) are an undeniable dimension of health. Tengland emphasises that this does not entail *any* positive moods and sensations, but those that have an 'immediate internal cause'. This provides a way to distinguish externally caused sensations and emotions like feeling lovesick, joy, or sadness from what Tengland calls 'health-related wellbeing' such as feeling energetic, being free from pain or feeling calm.[2] Thus conceived, ignoring inequalities in subjective health leads to what we could call 'perceived health neglect', and might be deemed just as problematic as 'physical condition neglect'.

Still, one might question what relevance inequalities in perceived health have for *justice*. This ultimately depends on whether we think this subjective aspect of health is part of citizens' *objective interests.* Rawlsian and capabilitarian theorists of justice tend to think of objective interests as of

> *'citizens' needs (...) defined objectively in virtue of a political conception of justice that takes the basic structure of society (...) as that for which citizens are jointly responsible.'* (Anderson 2010b, 86)

Considering the fact that there are systematic inequalities in perceived (i.e. subjective) health that correspond with socioeconomic inequalities, inequalities in subjective health are linked to society's basic structure for which citizens are jointly responsible. That is, they appear to be a product of the way in which a society is organised. However, one may question whether perceived health is really something that citizens ‘need to function as equals in the system of social cooperation’ (Anderson 2010b, 86), and thus as something citizens owe one another. While this may not always be evident, we should not exclude the possibility. Especially if we think of feelings like pain and severe stress, it is well imaginable how this affects a person’s functioning. As such, inequalities in subjective health are candidates for objective interests in so far we can hold other citizens accountable for their emergence, *and* in so far we consider self-perceived health to be an important aspect of health that might hinder people to function in the system of social cooperation.

To conclude, although quite a few justice theorists have emphasised that we need an objective account of wellbeing, or that health needs should be objectively ascribable, this *need* not imply that we should reject measuring subjective health judgements completely. If considered in addition to inequalities in objective health, we have good reasons to be concerned with inequalities in subjective health. One reason is that how healthy people *feel* can well be seen as an important aspect of being healthy which can only be indicated by the individual herself, for instance by self-perceived health measures. Moreover, like inequalities in objective health, inequalities in subjective health show a social gradient, and thus are at least partly determined by the way in which a society is organised, and as such candidates for inequalities for which citizens can hold each other responsible. And so, a concern with impartiality need not exclude the subjective perspective on health.

Equal treatment and the question of universal or relative standards

Also regarding the question of whether we should use a *universal* or a *relative* standard of health in measuring health inequalities, theories of justice seem to favour one of them, namely universal standards. For the idea that equal cases should be treated equally is, at least at face value, only compatible with universal criteria that apply to each person alike. As shown in chapter 2, Boorse and Venkatapuram defend a concept of health that is universal. Both apply criteria for ‘being healthy’ that are the same for each human being, respectively the criteria of normal biological functioning and of having effective access to Nussbaum's central human capabilities. In contrast, both Nordenfelt's and Huber et al.'s concepts of health allow that the criteria for being healthy may differ per individual, depending on what is important *for* (Nordenfelt) or *according to* (Huber et al.) the individual, which is of course likely influenced by her social and cultural environment.

Venkatapuram explicitly criticises Nordenfelt's account in the light of social justice, pointing to the risk of 'social and ethical relativism' (Venkatapuram 2013, 275), that he thinks Nordenfelt's concept of health is vulnerable to. And so, like with the question of subjective/objective health, adaptive preferences seem to be an issue here as well. That is, relative health standards are in need of a response to ethical relativism, if people tend to adjust their standards of health, in the sense of what Sen calls 'valuation neglect':

> *'Considerations of 'feasibility' and of 'practical possibility' enter into what we dare to desire and what we are pained not to get'* (Sen 1985, 21)

The moral problem of people's adjustments of their standards of what counts as healthy to what they are used to, is most pressing for the use of self-rated health measures. For if equal cases should be treated equally, and if people assess their own health in reference to different criteria or norms, addressing inequalities in terms of self-perceived health would imply the use of 'double standards'. This is especially problematic if standards of health differ in demandingness due to differences in socioeconomic circumstances. If we would then merely use the measure of self-perceived health to bring into view socioeconomic inequalities in health, this would result in an underestimation of these inequalities.

Although legitimate worries, they disappear if we follow the argument above that the measure of self-perceived health should always be accompanied with objective health measures. That is, as long as we take into consideration inequalities in objective health, the problem of adaptive preferences is controlled for. And so, in contexts where both self-perceived and objective health are taken into account, worries about adaptive preferences and ethical relativism do not problematically bear on the question of how we should *measure* health. That is, despite the possibility of adaptive preferences, the measure of self-perceived health can still be used.

However, the question of relative or universal standards of health *can* have implications for the goals of public health policies. And if public policies apply to all citizens equally, it seems to make sense that the aims and aspirations of these policies must be the same for each. Yet, this is not to say that the universal health standards as identified in chapter 2 are the best basis of public health. For instance, health equity can be aspired to in line with Boorse's universal standard of normal biological functioning (as defended by Daniels), or in line with Venkatapuram's universal standard, implying that the realisation of Nussbaum's central human capabilities is aspired to for each person. But regarding a Boorsian standard, it is not evident why *normal* biological functioning for each should be ultimately aspired. For as Schramme (2009) notes while discussing Daniels's theory: 'Normality as such does not seem to be of any value' (Schramme 2009, 19). Indeed, what matters *morally* is whether persons are able to do and be things they have reason to value (cf. Robeyns 2016).

Considering this, Venkatapuram's capabilities approach seems more appropriate. But in this regard, it is questionable whether it is up to theorists and philosophers to decide which functionings should be protected for social justice, as it is the case with the capability set defined by Nussbaum that informs Venkatapuram's theory. Notably Sen has been reluctant to defend a list of universal human capabilities, as he seems to consider people's capacity to decide for themselves which capabilities they have reason to value as a demand of respecting people as free agents, that exercise their 'agency freedom' through practical reason (e.g. Sen 1992). Also, in relation to health, Nordenfelt (2013, 7) doubts whether Nussbaum's 'practical reason', 'play' and 'other species' should be understood as *universal* capabilities (or in his terminology 'vital goals') to which health gives access, given that individual interests differ considerably.

And so, we may well be critical of the idea that public health policies should be guided by universal standards of health. For when adopting a Boorsian standard this may blind us to the more relevant question of what valuable doings and beings people are able to achieve. And when the latter has our focus, adopting a universal list of capabilities might blind us to the importance of self-determination (e.g. through the use of practical reason), and to the fact that different people may aspire to different goals in life.[3]

The question of whether it should be ultimately up to people themselves to decide what capabilities deserve protection, is a central point of dispute in the capabilities literature that I cannot resolve here (e.g. Sen 1992; Nussbaum 2003; Venkatapuram 2011). A central dilemma in this regard is that even if we consider democratic self-determination and practical reason to be important, there remains a tension with the risk of adaptive preferences: for what if people lower their aspirations of what they deem important in relation to – for instance – their disadvantaged socioeconomic conditions?[4]

As I discuss in the next section, in the context of public health, we have good reasons to take concerns of recognition and participatory parity of lower socioeconomic groups as a central part of health equity policies. This pleads for taking into account values and views regarding health by those groups that are subjected to public health policy targets.

The concept map study to the question of what should count as 'being healthy' is an example of how this could be done. At the same time, it appears that this concept map study indeed confronts us with the dilemma between recognising people's own values and their tendency to adjust their values to their circumstances. For – as I will argue – the concept maps reveal different standards of health per socioeconomic group.

II. The normative relevance of citizens' views on health

This section discusses the question of what reasons we could have for studying citizens' perspectives on health, if we are concerned with justice. It starts by showing why pursuing studies like the concept map study has moral importance, primarily by pointing out that from the perspective of what Fraser (2000) calls 'participatory parity', different conceptualisations of health should be taken into consideration in policymaking to ensure that subordinated groups, such as the lowest educated, do not suffer misrecognition. However, this comes with the question of *what to do* with knowledge of how lower socioeconomic groups think about health. For the concept map study reveals that different socioeconomic groups hold different standards of health, i.e. different views on what counts as being healthy. This raises the question of what relevance the findings could ultimately have for health equity policies.

Recognition and participatory parity

The pursuit of this concept map study was motivated by a concern for democratic self-determination. Referring to health as a partly evaluative concept, we suggested that conceptualisations of health among ordinary citizens are relevant for the legitimacy of public health policies. We stated that:

> *'the legitimacy of policies that aim at improving the health of people in lower socio-economic groups can be challenged if these policies do not reflect the conceptualisations of health that are valued in all strata. For instance, if policies tackling health inequalities primarily aim at closing the gap in mortality, while people subjected to those policies understand health primarily as 'health-related quality of life', it is questionable whether the policy-focus on mortality has sufficient public support.'* (p.59)

Now, we should start by noting that understanding 'policy legitimacy' as a matter of 'public support' is not self-evident (cf. Peter 2010). And so, whether the normative relevance of studies like these is best conceptualised by the terms 'legitimacy' or 'public support' is dubitable. For in contrast to explicit policies and regulations, the *conceptual* underpinnings of policies are generally implicit, and not subject to the democratic procedures that are often seen as providing these policies legitimacy.

But perhaps we do not need to talk about legitimacy or public support, to see that it is important that health promoting policies reflect an understanding of health that is prevalent among those subject to these policies. Especially if we understand health as an evaluative concept, a discrepancy between conceptualisations of health by citizens on the one hand, and the health concepts endorsed by policymakers and researchers (who provide the scientific basis for policies) on the other hand, entails a discrepancy in what is valued. As such this may result in a discrepancy in what *is* and what is *not* deemed problematic regarding health. In chapter 3, we mentioned the example of governmental aspirations to reduce health inequalities, and the common focus on mortality rates, whereas our and other studies suggest that many other aspects of health are valued by citizens, such as feeling well, and possessing particular mental and physical abilities.

More importantly, besides conceptualisations in general, we have also suggested that we should care about conceptual differences *between* groups. Regarding differences in health views between socioeconomic groups, we noted for instance that the increased attention paid by the WHO to the social determinants of health is a good development, because 'the person within his/her circumstances' appeared to be a salient feature of health for the lower educated group, which suggests that the social determinants of health are a broadly recognised aspect of health by these groups (cf. Smith & Anderson 2018).

This concern for differences between socioeconomic groups is motivated by acknowledging the fact that policies are generally designed and proposed by people with a higher educational degree (cf. Bovens & Wille 2017), and that there is therefore a risk that the interests and values of the higher educated dominate these policies. Put differently, people with lower educational degrees are generally underrepresented in democratic policymaking, and so are their perspectives and – potentially – their interests. This is problematic if we think that all persons have equal moral standing and should therefore be enabled to stand as equals in social and political life. Fraser (2000) explicates this as an injustice in the sense of misrecognition: groups become subordinated by not being recognised as full partners in social interaction.

The concept mapping study thus aimed to understand what values and perspectives regarding health prevail in groups with a lower education level, as the voices of these lower educated groups often remain unheard. As such, the study answers the call made by Blacksher (2012) – following Fraser's terminology – for more 'participatory parity' in public health to counteract misrecognition of subordinated groups. That is, if we think social justice demands equal social *standing*, disadvantaged groups should be enabled 'to participate on a par with the rest' (Fraser 2000, 113). Applied to public health, Blacksher (2012) argues:

> *Health research that fails to investigate and learn how community members view the problem fails to acknowledge their lived experience, renders them silent, and, in doing so, risks overlooking the real barriers to health.'* (Blacksher 2012, 323)

Although the participatory parity as Blacksher conceives of it is concerned with the intended goals and unintended effects of specific health *policies*, rather than with *conceptualisations* of health, these policies are – or so I assume – informed by particular understandings of health. And so, studying conceptualisations of health by disadvantaged groups is arguably relevant too. These conceptualisations should at least be considered when determining what health indicators are used to measure health, as these indicators inform policy aims. But also when notions like 'health needs', or 'the right to health' are specified, the views of subordinated groups should be considered if we are concerned with recognition. For the interpretation of these notions may differ depending on what people value, which may – as chapter 3 shows – be determined by their social position and conditions they live in. The general point is that studying the conceptualisations of health by lower positioned socioeconomic groups supports seeing these groups

> *'as agents of change and peers in the health equity project. Their insights and stories must be heard if we are to make progress on social justice together.'* (Blacksher 2012, 328)

Embracing the idea of participatory parity blurs or even dismisses the distinction between 'lay' views, and 'expert' views. This distinction is in this context indeed dubitable. For if we consider health to be an evaluative concept, it is plausible to take 'ordinary citizens' as the best experts available. But also regarding knowledge of the social determinants of health, the distinction between 'lay persons' and 'experts' may not be as strong as the terms indicate. As studies into public perceptions of health inequalities show, people in disadvantaged positions are well aware of the structural causes leading to inequalities in health (e.g. Putland et al. 2011; Smith & Anderson 2018). Taking the views of disadvantaged and marginalized groups into account may thus both contribute to knowledge about what they aspire to in terms of being healthy, as well as about the barriers to health these groups experience.

So, a concern with recognition and participatory parity provides a strong moral reason to pursue studies into citizens' views on health, especially into the views of subordinated groups such as in lower socioeconomic strata. However, it is one question to pursue studies like these, it is another what exactly we should do with their outcomes. Should we for instance formulate health equity goals that reflect the views on health that prevail in society? What if these views differ between social groups? In what follows, I interpret the outcome of the concept map study in line with a number of earlier sociological studies into health views that noted differences between socioeconomic groups. The aim is to clarify to what extent the concept maps reveal adaptive preferences, for this would speak against taking these views into account in making policies.

A social gradient in health standards?

Like other studies into 'lay' concepts of health (e.g. d'Houtaud & Field 1984, Calnan & Johnson 1985), the concept map study reveals differences between conceptualisation of health by people from different socioeconomic strata (indicated by education level). As such, the concept maps reveal differences in how people conceptualise health that seem to entail different *standards* of what counts as healthy.

Recall how we summarised the ways in which the conceptualisation of health by the lower socioeconomic group differed from the higher educated group:

> *'[P]eople in lower socio-economic groups were more likely to show a conceptualisation of health that refers to: 1) the absence of health threats (versus positive aspects), 2) a person within his/her circumstances (versus quality of own body/mind), 3) the value of functional (versus hedonistic) notions, and 4) an accepting (versus more active) attitude toward life.'* (p.75)

All in all, the way health was understood by the lower socioeconomic group appears to be a less demanding ideal, especially considering the emphasis on (1) the absence of health threats, (3) health as a functional good, and (4) the accepting (or rather: 'resigning') attitude towards life that speaks from the wordings by which this group characterised health.[5]

But perhaps it is too simplistic to read this as adaptive *preferences,* as it regards *conceptualisations* of health. Even if we understand health as a partly evaluative concept, thereby incorporating preferences and values, it also has a strongly descriptive dimension, by which it entails beliefs about more factual matters. To capture this descriptive dimension, we can broaden the category of preferences and desires so that it incorporates conceptualisations. To do so, we can see the concept maps as expressing what the sociologist Pierre Bourdieu called 'dispositions', referring to all kinds of (psychological) features such as beliefs, tastes and values.[6]

A Bourdieuan explanation of differences between socioeconomic groups in these dispositions, i.c. the meaning of health, is still strongly in line with the idea of adaptive preferences, as it explains dispositions as being formed by the circumstances in which people live. Moreover, interpreting the concept mapping study in accordance with Bourdieu's theory situates this study in relation to other sociological studies to health concepts and social class. For instance, d'Houtaud & Field (1984) describe their study to 'the image of health' as a follow-up on Claudine Herzlich's (1974) study of collective perceptions of health and illness. Both take Émile Durkheim's idea of 'collective representations' as a theoretical frame to study views on health and illness:

> *'In addition to the opinions, attitudes and behaviours that one observes in populations on the subject of health, there is an even more fundamental question: it is that of representations, in the sense used by Durkheim, or basic consciousness or general world-view that underlie these opinions, attitudes and behaviours.'* (d'Houtaud & Field 1984, 31)

Now, Durkheim uses the concept of collective representation to study the common morality of societies or communities or 'collective conscience', i.e. 'the totality of beliefs and sentiment common to average citizens of the same society' (quoted in Ritzer & Douglas, 164). This collective conscience is only tangible via collective representations, such as religious symbols and popular legends (Ritzer & Douglas 2004, 165), but also by 'categories of understanding' (Bourdieu & Wacquant 1992, 11). And so, following Herzlich (1974), d'Houtaud & Field (1984) took 'health' as a collective representation of that part of common morality that relates to health and illness. They studied what French people in general understood by 'health', and only after analysing this, they found that socioeconomic class was a discriminating variable. They subsequently described the difference in the concepts of health between lower and higher socioeconomic groups as one of 'functional vs hedonistic' views on health. Like the study by Calnan & Johnson (1985), the concept maps in our study also reveal differences that – as we have argued – can well be characterised by this distinction.

Noting differences between groups, making the shift from Durkheim's theory to that of Bourdieu as I suggest here, is a natural one. For Bourdieu shared Durkheim's interest in the consciousness and perception of agents, and in their reproductive force. Both thought that it is by their beliefs and perceptions that individuals act upon and produce the material world, while the material world acts upon and produces the lived experience of individuals. But whereas Durkheim looked primarily at the *collective* conscience of societies or communities as a whole, Bourdieu looked at societies as 'social spaces' constituted by different 'fields' (i.e. spheres, or realms), such as the academic field, the art field and the economic field. It is through these fields – and their particular rules – that individuals struggle to acquire economic, but also social and cultural capital. The unequal distribution of these three forms of capital results in differentiated positions in society, which come with power, and as such indicate what we usually call 'social class'. So, for Bourdieu, social classes are formed by what position agents occupy within a society ('social space') given the distribution of different forms of capital.

What is interesting for our concern here, is that given that people are differently positioned, they live in different 'objective' social and material conditions. And, as Bourdieu follows Durkheim in that there is a constant interaction between objective conditions and subjective experience, different groups develop different *dispositions*, i.e. 'perceptions and appreciations' that 'structure their action from the inside' (Bourdieu & Wacquant 1992, 11), and that are 'acquired by internalizing a determinate type of social and economic condition' (Bourdieu & Wacquant 1992, 105). In this regard, Bourdieu's notion of dispositions strongly echoes the idea of adaptive preferences:

> *'In reality, the dispositions durably inculcated by the possibilities and impossibilities, freedoms and necessities, opportunities and prohibitions inscribed in the objective conditions (…) generate dispositions objectively compatible with these conditions and in a sense pre-adapted to their demands. The most improbable practices are therefore excluded, as unthinkable, by a kind of immediate submission to order that inclines agents to make a virtue of necessity, that is, to refuse what is categorically denied and to will the inevitable.'* (Bourdieu 1990, 54)

In this light, we may explain the four – by us identified as most remarkable – differences between the conceptualisations of health of different groups as 'dispositions compatible with the conditions' in which these groups live. Or, in other words, as disclosing the lived experience common within these groups. Specifically, the emphasis on the absence of health threats (1) is more compatible with circumstances where health is regularly threatened, while emphasising positive aspects of health is compatible with circumstances in which there is an 'abundance' of health (that is, where the absence of physical and mental problems is an unquestioned and taken for granted reality). Similarly, valuing health as a functional good (3) is more congruent with lives that are marked by various obstacles to getting the basics settled, than with lives in which these basics are given and health is valued as a 'hedonistic' good. A resigning attitude towards life (2) fits better with living in dependency, whereas a more active attitude towards life better fits the experience of feeling in control. Also, conceiving health as a quality of the person within his/her circumstances (4) reveals the experience of dependence, while health as a quality of one 's own body and mind reveals the experience of self-determination.

So, initially, it seemed inappropriate to understand the different conceptualisations of health as adaptive *preferences*, given that health concepts are only partly evaluative and entail 'factual' beliefs as well. Nevertheless, interpreting the concept maps with the help of Bourdieu, shows that conceptualisations of health clearly resemble the structure of adaptive preferences. That is, the conceptualisation of health of different socioeconomic groups reveal different dispositions towards health that are likely formed by and reflect differences in socioeconomic circumstances.

Escaping a dilemma?

This shows the dilemma that I anticipated at the end of the first section: should policymakers recognise different values of different socioeconomic groups, and bring policy goals in line with them, or should these values be ignored, given that people tend to form their norms and values to their socioeconomic circumstances, and as such do not reflect people's true interests?

Perhaps we can say that studies like these contribute to participatory parity, in the sense that listening to the views of lower socioeconomic groups – who are generally excluded from policy making – inform policymakers how these groups experience what being healthy entails. For instance, this study suggests that to be healthy is experienced by these groups as depending on the social and material environment, and that living without illness is less taken for granted. Such findings may help policymakers make policies that align with the values and living conditions of the social groups that are subjected to these policies.

However, in so far lower socioeconomic groups show dispositions that can be interpreted as different standards of what being healthy *demands*, conceptualisations of health should not be taken as something to be directly translated into policy goals. For this would imply – if we would follow this concept map study – that health policies should foster 'lust for life', 'independence' and 'enjoyment' for the highest socioeconomic groups, and only foster the absence of 'stress', 'chronic disease' and 'attention by doctors' for lower socioeconomic groups. While this would take into account the highest valued aspects of health by each group, this would obviously violate the principle that equals should be treated equally, and as such have little to do with justice.[7]

Considering the health indicators that are commonly used to measure health inequalities – e.g. life expectancy without disease and disabilities, life expectancy in good perceived health – the concept map study gives reason to think that the conceptualisations of health by lower socioeconomic groups align well with how we measure health. And so, these groups do not suffer misrecognition in the context of current health measurements.

But suppose this would *not* be the case, and that policymakers and researchers would have developed health measures that merely or primarily reflect the health views by the higher socioeconomic groups. This would certainly confront us with a tension between participatory parity and equal treatment. This hypothetical – though not unimaginable dilemma[8] – could be settled by basing public health policies not on *group-relative* health concepts, but on *society-relative* standards of health. That is, participatory parity may also be served if understandings of health that are valued by *different* socioeconomic groups in society guide public policies. For setting aside the differences between groups, the concept map study also reveals *shared* views on health. In this regard, we noted that all groups have a multidimensional view of health, and that each group indicates mental health as the number one in terms of importance.

Arguably, such shared views should be considered if we reconsider the ways in which health inequalities are measured, for instance by paying more attention to mental health than is currently done. For while life expectancy in good mental health is one indicator of health that is used in the Netherlands to express inequalities in health, the overall focus in public health policies seems to be on health in terms of absence of physical disease and impairments. Citizens' views on health also support the idea that a larger variety of indicators of health should be used. How exactly to broaden the scale of health measures would demand further research, given the limited representativeness of the concept map study.

Although a broader range of health measures would not bring us closer to an answer to the question of which health inequalities to focus upon, the point here is that justice *can* be served by taking *society-relative* standards of health into account, whereby different societal groups are heard and are treated equally. Given that values and norms regarding health may differ per society, justice does not require that public health goals are based on universal standards of health in the sense that it applies *exactly* the same standard to all human beings a like.[9]

Conclusion

In this chapter, I have discussed how theoretical and citizens' concepts of health are relevant if we are concerned with the (in)justice of health inequalities. Theoretical health concepts highlight different aspects of health and as such offer different perspectives of what should be the focus of health policies and measurements. Regarding the questions of subjective or objective perspectives on health, and of universal or relative standards of health, I have shown that arguments to give most weight to universal and objective metrics of justice, need not apply to health measures. That is, subjective health measures, like self-perceived health, arguably capture an indispensable aspect of health that cannot be measured otherwise. If we thereby consider that inequalities in subjective health are determined by the way a society is structured, they are relevant for justice. Moreover, while universal health standards may guarantee that equals are treated equally, they tend to ignore concerns of recognition and participatory parity.

It is in the light of this tension – between equal treatment and participatory parity – that I have discussed the relevance of the concept map study. The idea that policymakers in public health should listen to which aspects of health are valued by especially lower socioeconomic groups was an important motivation behind this study, which I here explained as the aspiration to contribute to participatory parity. At the same time, this study could be interpreted as revealing mechanisms very similar to adaptive preferences, in the sense that health standards differ in demandingness per socioeconomic group. This potentially confronts us with a dilemma: should we recognise different values and apply different standards of health – i.e. different policy aims – for different groups? Or should we treat people as equals, and thus use the same standards and policy aims for all? The way out that I have suggested, is to let studies like this concept map study inform public health policies, for instance by enriching health measures in the light of what is deemed important by *all* groups, thus using a society-relative, rather than a group or individual relative health standard.

Based on this analysis it seems that the studies to concepts of health do not provide clear clues regarding the question as to which health inequalities should be focused upon from a justice perspective. For considering these conceptual studies in the light of a concern with impartiality and equal treatment, both inequalities in subjective *and* in objective health measures are relevant for considerations of justice. And considering a concern with recognition and participatory parity, there may even be more aspects of health that are currently not, or insufficiently monitored. But that would require more empirical investigation into citizens’ views on health and further analysis of how these aspects could be measured.

And so, we may conclude that inequalities in all commonly used health measures – that is, in terms of life expectancy, in disease prevalence, in disability prevalence, in mental health, and in perceived health – are potentially relevant for considerations of justice. It thus seems that more needs to be said about what makes these observed health inequalities possibly unjust. This brings us to the question to which the next chapters are devoted: how exactly should we evaluate the (in)justice of inequalities in health as they are commonly measured?

Notes

1. Regarding the issue of whether health should be seen as internal or circumstantial affair, I here just assume that a moral concern with socially determined health inequalities should involve a concern with social and material circumstances. Whether the latter are understood as part of a person's health or not, does not depend on significant normative concerns. For instance, criticism of the width of Venkatapuram's concept – which takes circumstances as part of a person's health – seems to boil down to a question of linguistic intuitions, and the fear that everything becomes a matter of health. See e.g. Nordenfelt (2013) and the contributions to the special issue of Bioethics 30(1) on Venkatapuram's health concept.

2. I will not defend this distinction between internally and externally caused feelings here, but only suggest that this is one plausible way to discern experienced or subjective health, from other feelings and emotions.

3. Capability theorists may justly object that capabilities – as referring to effective opportunities – leave people free to choose, and that any list of capabilities leaves people free to aspire different things. But if public health policies are guided by a particular list of valuable capabilities, this may nevertheless have a steering effect as well as ignore capabilities that are deemed valuable by some.

4. See Argenton and Rossi (2013) and Wells (2013) for discussions of this tension between self-determination and adaptive preferences in Sen's work.

5. As pointed out in footnote 1, regarding second difference, i.e. '2) a person within his/her circumstances (versus quality of own body/mind)', I assume that this does not give rise to substantial normative considerations. Still, it is relevant to point out once more that this shows how the concept maps seem

to reflect the social and material living conditions of each group (chapter 3; see also Smith and Anderson 2017).

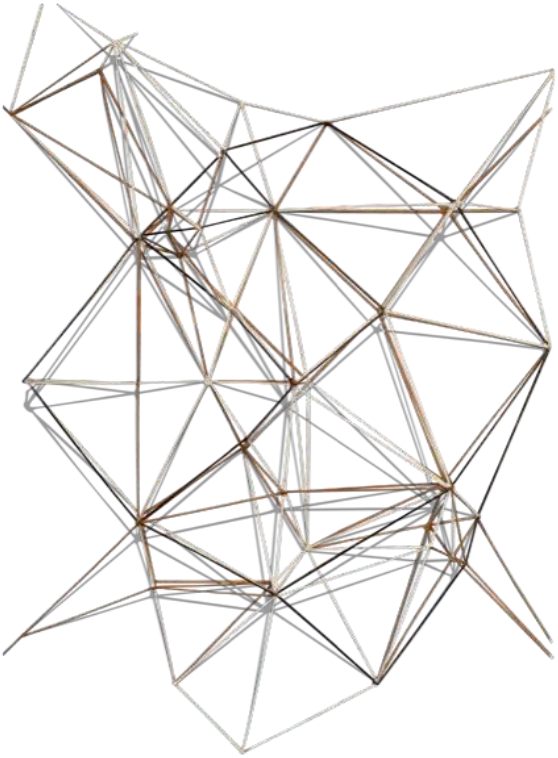
6. I thank one of the reviewers of the concept mapping study for this suggestion.

7. Besides, this would raise the question how the promotion of 'lust for life' would be an objective or fundamental interest.

8. In the Netherlands for instance, the concept by Huber et al. finds broad support, which gives rise to the question of whether it should be translated into health measures for measuring population health. In the light of participatory parity, this would be a dubitable development, as the concept is also criticised for resonating especially values of higher socioeconomic groups, such as the importance of self-management, personal development and flourishing (Buijs 2017), as well as for downplaying the social determinants of health (Jambroes et al. 2015).

9. This of course immediately invokes the question of what principle difference there is between societies, social groups, and 'mankind'. I will leave this question undiscussed, as my concern here is with health inequalities within nation states.

PART II:
Justice evaluations



Chapter 5

Can people be healthy enough? Evaluating health inequalities from a sufficientarian perspective

Chapter 5 Can people be healthy enough? Evaluating health inequalities from a sufficientarian perspective

Introduction

The evaluation of socioeconomic inequalities in health can be pursued directly – by considering health inequalities as of independent moral concern – and indirectly – by evaluating the justice of the distribution of the social determinants of health (e.g. Peter 2001). In this chapter, I explore direct evaluation, meaning that we evaluate health inequalities in reference to an ideal distribution pattern of health outcomes. While direct evaluation is mostly conceived of in relation to the ideal of *equal* outcomes in health, I will here examine the ideal of *sufficient* health. This perspective deserves further examination, as it might indicate that some health inequalities are not unjust, *if* they emerge above a certain minimum. By considering the simple question of whether we can be healthy enough, I aim to clarify why the idea of sufficient health is a good moral focus for justice, *but also* why the perspective of sufficient health is of little help in the evaluation of socioeconomic health inequalities.

Although quite a few philosophers have defended a sufficientarian position in relation to health, they have generally been reluctant to specify what exactly to understand by sufficient health. This is understandable, given that it is hard to define minimum levels for health that are not morally arbitrary. For instance, we could consider the World Health Organisation's norm of 'premature death' of 70 years as a minimum level for life expectancy. This norm seems to be based on the global average life expectancy of 71 years (e.g. WHO 2015). Should we base our justice evaluations of health inequalities on the WHO's standard of premature death? While empirical averages are not irrelevant, to take them as the only criterion for discerning just from unjust health inequalities seems to fall short, as this evokes questions like if and why we should look at average rather than modal life expectancy, or if and why we should look at global average rather than national or regional average.

After briefly explaining why direct evaluation from a sufficientarian perspective is an approach worthwhile exploring, I will discuss two distinct ways to define health thresholds. The first is to understand minimum health as what is feasible given the societal context, as suggested by Powers & Faden (2006). The second is to derive a health threshold from a moral ideal, for which I take Nussbaum's ideal of 'a life in human dignity' as an example. As I will argue, both routes lead us to thresholds for health that are morally arbitrary. Although in practice, working with morally arbitrary thresholds may be unavoidable, I here take it that for justice evaluations, we need sound arguments. Therefore, I propose to save the idea of sufficient health as the moral outlook, while letting go of the aspiration to set an independent threshold for health.

I. Direct evaluation of inequalities in health from a sufficientarian perspective

Direct evaluation

The (un)fairness of socioeconomic inequalities in health within countries has been subject of considerable debate, in which one of the central questions has been how to distinguish just from unjust health inequalities (e.g. Preda & Voigt 2015; Sreenivasan 2009; Wester 2018; Wilson 2011). As pointed out above, two evaluative approaches can be distinguished in this debate. One is to evaluate socioeconomic inequalities in health in an 'indirect' or 'derivative' way (Peter 2001; Sreenivasan 2009, 2014). This means that the fairness of inequalities in the *social determinants* of health – e.g. income level, education level – are evaluated to judge if the resulting inequalities in health are unjust (e.g. Daniels et al. 1999; Daniels 2008; Peter 2001).

I will here consider the approach of 'direct' or 'freestanding' evaluation (Peter 2001; Sreenivasan 2009, 2014), that addresses the more fundamental question of inequalities in health *as* health inequities. For as Sreenivasan (2009) points out, also if there would be a perfectly just distribution of the social determinants of health, such as of income level, there could still be inequalities in health. The reason for this is that a *just* distribution of the social determinants of health is not necessarily an *equal* distribution, and thus inequalities in health may remain. These remaining inequalities are referred to as 'residual' inequalities: 'avoidable health inequalities the causes of which are otherwise fair' (Sreenivasan 2009, 245). To see if these residual health inequalities are unjust, some have argued for 'direct' or 'freestanding' evaluation (Anand & Peter 2000; Sreenivasan 2009; 2014). This implies an evaluation of the fairness of health inequalities *qua* health inequalities, regardless of the fairness of their social causes. Only direct evaluation would properly recognise health inequalities as raising 'independent problems of social justice' (Anand & Peter 2000).

Understanding health inequalities as an independent problem of social justice, is especially convincing if we want to recognise health as a good that is of fundamental importance for our wellbeing such that it deserves public protection, regardless of how well we are doing in other respects. Such a view is notably defended by Martha Nussbaum, who has formulated a list of 'central human capabilities' that together constitute a life in human dignity (e.g. Nussbaum 1999, 2011). The first two capabilities on the list are

> *'1. Life: Being able to live to the end of a human life of normal length; not dying prematurely, or before one's life is so diminished as to be not worth living*
> *2. Bodily health: Being able to have good health, including reproductive health; to be adequately nourished; to have adequate shelter'* (Nussbaum 1999, 235)

As central human capabilities, a long life and good health are thus considered as indispensable constituents of a life in human dignity such that deficiencies in these capabilities cannot be compensated for by improvements in other capabilities (e.g. Nussbaum 1999). For example, respiratory problems cannot be 'compensated for' by higher levels of the capability to have social affiliations. Similarly, Powers & Faden (2006, 6) argue that health is one of the six 'essential dimensions of wellbeing', and as such of 'independent moral significance'. Both Nussbaum and Powers & Faden assume that being healthy is something that is 'of central importance whatever else the person wants to pursue' (Nussbaum 1999, 234) or 'reasonable for anyone to want, whatever else they want' (Powers & Faden 2006, 6).

Sufficient health

Thus far, proposals for direct evaluation of health inequalities have primarily aimed for *equality* in health outcomes or *equal* opportunities to health (e.g. Culyer & Wagstaff 1993; Sreenisavan 2009). As such, direct evaluation takes any avoidable inequalities in health as unjust (e.g. Whitehead 1990; Commission on the Social Determinants of Health 2008). Although direct evaluation – given its concern with health inequalities as independent issues of justice – is worthwhile exploring, the idea that *equality* in health should be the ultimate moral aim is questionable.

One reason for this is the so-called 'levelling down objection' (e.g. Parfit 1998). Applied to health, this objection states that striving to equal health outcomes should make us 'prepared to destroy the health of those who do best in order to reduce inequality' (Wolff 2015, 39). Now, levelling down need not be a bad thing, if it advances the worst-off substantially (cf. Powers & Faden 2006). But while it is conceivable that goods that can be redistributed may advance the worst-off, it is harder to imagine that bringing down the health of the best-off would improve the health of the worst-off.[1] The levelling down objection is not a 'knock-down' argument against any equal distribution patterns, as it can be objected that this is just the wrong way of applying equality as distributive rule in practice. Also, equality in certain goods can be of instrumental value (cf. O'Neill 2008; chapter 7).

Still, the levelling down objection helps to see that the injustice at stake in health inequalities may not be the unequal distribution patterns *as such.* To put the point differently, we may question how equality in health can be justified as a demand of social justice. Anderson (1999) notably argues that neither envy nor pity are a proper basis for making claims of justice, and that only needs, or objective interests, can indicate what we owe to each other. It is not immediately clear that being equally healthy is an objective need (though see chapter 7), while this is more plausible to say of being healthy enough. In fact, to think in terms of 'needs' already *presumes* a sufficientarian perspective, since needs can be fulfilled.

This may explain why the core idea of sufficientarianism is so morally appealing: if everyone has enough, no one falls short. Harry Frankfurt has been one of the first who defended – what he called – the 'Doctrine of Sufficiency', arguing that:

> *'(…) what is important from the point of view of morality is not that everyone should have the same but that each should have enough.'* (Frankfurt 1987, 21)

Recently, sufficientarianism has received particular attention in relation to health and health care. As Fourie & Rid (2016) write in the introduction to their book *What is Enough? Sufficiency, Justice and Health*:

> *'It seems prima facie reasonable to claim that everyone should be provided with "enough" health care for maintaining a good quality of life. These answers seem to point to the idea that sufficiency of health or health care could be an important aim of social justice and public policy. (…) Helping individuals to achieve sufficient life spans, seems to be an intuitively more appealing aim of health policy than, for instance, helping them achieve equal life spans.'* (Fourie & Rid 2016, 2)

Also, both Nussbaum (e.g. 1999, 2011) and Powers & Faden (2006) argue that what needs protection for reasons of justice is a minimal level of health, rather than equal health levels. And their proposals are accompanied by many other – primarily capability – theorists. As shown in chapter 2, by building on Nussbaum's theory, Venkatapuram (2011) argues that one should have sufficient health in order to achieve sufficient levels of Nussbaum's central human capabilities (Venkatapuram 2011).[2] Similarly, Efrat Ram-Tiktin (2011) argues for a basic health level as a precondition for those 'basic human functional capabilities' that are required for a good life.

Now, as Casal (2007) points out, sufficientarianism entails both a positive and a negative claim. The positive claim is that everyone at least deserves a basic level of the relevant good (i.c. health). The more controversial flipside of this is that inequalities above that minimum are irrelevant from the point of view of justice. This shows how sufficientarianism sets limits to what justice demands. And so, for sufficientarian direct evaluation of health inequalities, the positive question is whether the least healthy fall below the minimal level of health. Negatively, if the health levels of the least healthy go beyond this minimum, health inequalities no longer raise issues for justice. Perhaps contrary to the intuitions of many, sufficientarian direct evaluation might thus tell us that some significant inequalities in health are *not unjust*. That is, a sufficientarianist *pur sang* would think that socioeconomic inequalities in health form no problem for justice *if* the lowest socioeconomic groups satisfy the minimum health level. Axelsen & Nielsen (2015) indeed defend this position, by arguing that inequalities in a good like health are morally irrelevant, because health would be a 'non-positional' good, meaning that the value of a good (like health) for an individual, is independent of how much others have of it (i.e. how healthy others are). To this issue of health as a (non-) positional good and the moral relevance of inequalities above a threshold, I will return below. For now, I will examine sufficiency as an appealing aim for social justice, and that it is therefore worthwhile to consider sufficient health as an alternative to equal health for direct evaluation.

Defining thresholds for health: a contextual approach

To see whether the idea that we need sufficient health offers a plausible and useful approach for the direct evaluation of inequalities in health, we should consider what to understand by 'sufficient health'. Perhaps one of the most elaborate accounts of how to understand sufficient health is provided by Powers & Faden's *Social Justice: The Moral Foundations of Public Health and Health Policy.* Their theory is very similar to the capability theory by Nussbaum, especially given its multidimensional understanding of wellbeing and human flourishing. Powers & Faden's account primarily differs from Nussbaum's in its emphasis on outcomes or functionings, rather than on capabilities, and in which specific dimensions of wellbeing they attach importance to (e.g. Powers & Faden 2006, §2.6). But as noted above, like Nussbaum, Powers & Faden take 'health' as one of the central dimensions of wellbeing, which they understand in accordance with

> *'the ordinary-language understanding of physical and mental health that is intended to capture the dimension of human flourishing that is frequently expressed through the biological or organic functioning of the body.'* (Powers & Faden 2006, 17)

As such, they do not provide a rigid definition of health, which allows us to apply their account to commonly used indicators of health inequalities, such as in terms of life expectancy, life expectancy in good mental health, life expectancy without disabilities and life expectancy without disease.[3] And just as they do not formulate strict criteria for health, they do not give criteria for what should count as *sufficient* health. By explicitly advocating non-ideal theory, they assume that:

> *'for many aspects of well-being there is frequently substantial agreement about the general range of normal functioning, permitting widely shared judgments that below some defined threshold, someone is malnourished, inadequately sheltered, or burdened by preventable disease or disability and a shortened life span. Thus, while absolute measures of sufficiency of the essential dimensions of well-being may be controversial at crucial points, there are many uncontroversial instances in which we know that the minimal level is not met.'* (Powers & Faden 2006, 58)

Due to this reliance on existing 'substantial agreement' and 'shared judgments', what counts as sufficient health is dependent on particular social contexts:

> *'Sufficiency for any dimension of well-being will be relative to the* level of social organization and technological and scientific development *in which that dimension must be realized. Because the ultimate focus of justice for us is on what persons ''can do and be,'' there simply is no way that such judgments can be made apart from some understanding of the background conditions that define the parameters of legitimate aspirations for justice.'* (Powers & Faden 2006, 60, emphasis mine)

So, according to Powers & Faden's account, the question of what counts as having a sufficient healthy life expectancy – however indicated – cannot be answered in the abstract but depends on what is achievable in a particular society, and is contingent on that society's social, technological, and scientific development. Thus conceived, evaluating inequalities in healthy life expectancy in the light of sufficient health requires a shared conception of what we may aspire to in terms of health. However, if ideas about what health thresholds should be aspired to are determined by what seems achievable in a given society, these aspirations may run in very different directions. For instance, it could be argued – as Powers & Faden do – that the groups that do *best* in terms of health reflect what is achievable in that society and should thus be taken as the threshold to which the groups that do worse should be raised:

> *'Sometimes, for example, the health gap between the better off and worse off is evidence that what counts as a sufficient level of health that is possible for a particular society or at a particular level of technological and economic development has not been accorded to some persons.'* (Powers & Faden 2006, 61)

The implication of this view is that a direct evaluation in the light of *equal* health, and in the light of *sufficient* health are the same, as both approaches take it that any avoidable health disparities are unjust:

> *'That some fare worse in terms of health outcomes is not, for that reason alone, necessarily unjust according to a sufficiency view; but health disparities may be deemed unjust when they are avoidable outcomes.'* (Powers & Faden 2006, 61)

The problem is not that egalitarianism and sufficientarianism could have the same implications (as I argue below, this is in fact quite plausible). What is problematic for direct evaluation is that the criterion of 'avoidability' as such gives little moral guidance. For contrarily to Powers & Faden's (progressive) interpretation of avoidability, it could *just as well* be argued that inequalities in health are 'unavoidable' in the sense that they reflect feasible health levels for different socioeconomic groups given a society's 'level of social organization'. Thus conceived, by deriving health thresholds from particular social contexts, inequalities in health can be deemed just or unjust, depending on what is deemed 'possible' or 'avoidable', which in turn depends on political ambitions regarding e.g. socioeconomic equality.

By appealing to the idea of avoidable outcomes, Powers & Faden's account concurs with the normative commitments that can be found in policy documents on health equity by e.g. the WHO (e.g. Commission on the Social Determinants of Health 2008; Whitehead 1990; WHO 2014). Preda & Voigt (2015) notably argue why 'avoidability' is neither a sufficient nor necessary criterion to demarcate just from unjust health inequalities. They point out that if avoidability is understood as preventability, it may not consider natural inequalities in health as deserving compensation. Especially relevant for socially determined inequalities in health, such as socioeconomic health inequalities, is that to say that 'something can be done about them is not enough to indicate that it should be done' (Preda & Voigt 2015, 30). For instance, it raises the question of whether inequalities in the social determinants of health – such as in income or education level – are to be levelled because this would avoid (or at least constrain) inequalities in health. And so, setting a threshold for health that is contingent on what health deprivations are avoidable in a given social context does not suffice for the evaluation of the justness of health inequalities. For justice evaluations, more needs to be said about why and what health deprivations a society is *due* to avoid.[4]

Defining thresholds for health: an external approach

Another route for sufficientarian direct evaluation is to justify health thresholds by an *external* normative criterion. Nussbaum's ideal of a 'life in human dignity' that is constituted by ten central human capabilities[5] offers a criterion that – to some extent – transcends existing social circumstances. However, it should be noted that criteria for capability thresholds are not entirely 'external', given the method Nussbaum herself advocates for specifying these central human capabilities. In her earlier writings, Nussbaum argues for instance that the list is composed and formulated by what she calls 'evaluative inquiry': an investigation of the question 'which things are so important that we will not count a life as a human life without them?' (Nussbaum 1992, 208). According to Nussbaum, this question can be answered without 'external metaphysical foundation', but 'stands within human experience' (Nussbaum 1992, 208). In later work, Nussbaum moves towards Rawlsian political liberalism and argues that the ten central human capabilities would also be subscribed to by 'Socratically deliberating individuals' (Nussbaum 2011, 77-79).[6] If basic levels of capabilities are to be set by deliberation about what is deemed acceptable in the light of human dignity, the question of what to count as a human life of normal length and in sufficient health is likely – and according to Nussbaum rightly so – informed by empirical knowledge about what is common and feasible in terms of longevity and prevalence of disease and disability. Moreover, Nussbaum (e.g. 2000; 2003) foresees that such deliberation should take into account the history and constitution of the particular society where the threshold applies, and so, such deliberation may not lead to different conclusions than the account by Powers & Faden.

Still, the ideal of a life in human dignity *does* provide *some* external moral norm, such that thresholds need not be entirely contingent on what is feasible given societal circumstances. While Nussbaum argues that specifications of the central capabilities and their thresholds could differ per society, she also argues that in their most generic formulation, they would be endorsed by *all* (deliberating and evaluating) human beings. She thereby assumes that in deliberation about the question of what constitutes a life in human dignity, we can 'balance concerns for history and culture against the demands of a universal norm' (Nussbaum 2000, 126).

What could this imply for minimal levels of the capabilities 'Life' and 'Bodily health'? To start with 'Life': if human experience is deemed a proper source of information, we may start by taking into consideration the WHO's definition of premature death – i.e. not dying before the age of 70 – that accords with the average life expectancy globally measured of 71,4 (WHO 2015). As pointed out above: to base an ethical standard merely on empirical data is morally arbitrary, in so far we may question why we should not look at modal life expectancy, or the highest attainable life expectancy? With Nussbaum's ideal of a life in human dignity, it could be argued that living up to the age of 70 at least enables people to endure a 'normal life course', in the sense that they could experience the phases of childhood, parenthood and grandparenthood. And that the opportunity to experience these phases of life, is central to a life in human dignity.

Now, apart from the fact that this raises the question of why not also include 'great-grandparenthood', this additional argument to justify a threshold for life expectancy suggests that it is not longevity *itself* that constitutes a decent life. Rather, it seems that to live a long life enables people to pursue other valuable things. In other words: the ideal of a life in human dignity in itself has no clear normative implications for a minimum of life expectancy but rather seems to form *a precondition* to achieve other capabilities.

Regarding the capability 'Bodily Health', we could consider today's global average of healthy life expectancy[7], that is 63 years (WHO 2015). Apart from the fact that we may dispute here too whether average should set the minimum for Bodily Health, it seems crucial here to question what a certain minimum for life expectancy without disease or disability *actually* tells us about the dignity or decency of people's life. Firstly, we should note that what counts as 'disease' differs per measures and data that are used. For instance, according to the WHO measurements, the average healthy life expectancy in the Netherlands is 73 years (WHO 2015). But according to Dutch measures, people in the Netherlands live on average without chronic diseases only until the age of 43,5 and without physical disabilities until the age of 71 (CBS 2016). This difference can be explained by the fact that Dutch statistics are based on data provided by Dutch GPs, and that the latter have intensified the registration of chronic disease prevalence among their patients since 2009 (Gijsen et al. 2013). Besides, early diagnosis due to well-accessible healthcare may further distort the picture: what is reported as chronic disease by Dutch data, might not (yet) be as severe as what is counted as disease by the WHO. And so, defining a threshold for healthy life expectancy would require that due attention is paid to what measures and data tell us, since physical and mental conditions vary in their impact on the quality of a person's life by their variations in type and in severity.

Secondly, when it comes to the impact of disease and disability on a person's quality of life, one of the key insights of the capabilities approach should not be overlooked. Namely that the effects of diseases and disabilities on what a person is *practically* able to do and be strongly depend on that person's social and material circumstances. This is not only acknowledged by capability theorists, but also well-illustrated by Broome (2002), who notes that:

> *'Asthma is less bad if you are well housed, mental handicap less bad in supportive communities, deafness less bad if you have access to the internet. Conversely, features of a person's health affect the value of other things: radios are no good to the deaf, nor running shoes to the lame. The interaction between health and other features of a person's life is so intimate that health cannot be treated as separable.'* (Broome 2002, 95)

The insight that practical circumstances ultimately determine what people are effectively able to do, is also often pointed out by disability theorists. Especially advocates of the social model of disability have indicated how both the social and physical environment construct disability, or at least importantly contribute to 'making' people with mental or physical impairments disabled (e.g. Barnes 2016).

If we take this interaction of circumstances and physical and mental conditions into consideration, we could even argue that Nussbaum's perspective of human dignity bears the suggestion that within developed countries, the health threshold could be set lower, given that living conditions here are generally much better than in developing countries. That is, the more comfortable one's living conditions, and the more resources one has in order to soothe the effects of illness, the more functionings one is able to achieve.[8] Even if health cannot be compensated for by other capabilities, it seems odd to say that a person living in Germany with a healthy life expectancy of 45 years, is worse-off than a person living Malawi with a healthy life expectancy of 60 years, given the overall differences in quality of health care and living conditions.

And so, we may question the usefulness of understanding health as a self-standing capability of which an independent minimum level should be protected. For also with the normative guidance of a life in human dignity, we cannot set non-arbitrary thresholds for life expectancy and healthy life expectancy. As the brief discussion of a threshold for longevity shows: justifying a minimum for longevity invokes the argument that a long life is of instrumental value for other capabilities. And regarding thresholds for healthy life expectancy, it seems clear that we need to take into account that the detrimental effects of health problems is strongly determined by social and material circumstances.

II. The limits of direct evaluation?

Thus far, I have distinguished two ways of specifying threshold levels for health. One is to determine a health minimum based on what is feasible in a given society, or put negatively, to consider what health deprivations are avoidable in a given society. I have thereby pointed out that the notion of avoidability as such provides insufficient moral guidance for the direct evaluation of health inequalities. And so that, taking this contextual approach, more needs to be said about the question of what health deprivations society is due to avoid, which also entails the question of what is due in terms of reducing socioeconomic inequalities.

The second route is to define sufficiency levels in the light of an external moral ideal or standard, such as living a life in human dignity. Because material and social circumstances importantly determine the ways in which (physical and mental) disease and disability affect what people are able to do and be, I have argued that – for this external approach – it seems to make most sense to understand health and longevity as instrumental values to achieve that ideal.

We can see that both these sufficientarian ways of evaluating socioeconomic health inequalities lead us away from direct evaluation. For the justification of thresholds for health and longevity appears to depend on how we evaluate other factors: respectively the distribution of the social determinants of health, and the consequences of diminished health for people's capabilities. As such, the very moral relevance of an independent threshold for health – that seems needed for direct sufficientarian evaluation – becomes questionable.

The above discussed routes of evaluation are – implicitly – further explored in the next two chapters, which both can be read as self-standing analyses. That is, chapter 6 can be read as taking up the first route, as it examines Daniels's adjustment of Rawls's theory and Daniels's proposal for indirect evaluation to normatively demarcate the category of avoidable health inequalities.[9] Chapter 7 can be taken as a continuation of the second approach, as it considers the interaction between health and social and material circumstances by making a proposal for instrumental evaluation.

However, both chapters adopt the ideal of relational equality, instead of the ideal of a decent human life, as the aspiration for social justice. While the two ideals are not *fundamentally* different, there is an important difference in emphasis, respectively on the quality of a person's life, and on the quality of social relations. To make a case for that choice in normative outlook, the remainder of this chapter argues that – even though related – the perspective of relational equality is more helpful in the evaluation of socioeconomic health inequalities in high income countries than the perspective of a decent human life. This discussion asks some patience of the reader, as it anticipates the analyses in the next chapters, which (partly) provide the 'proof of the pudding' of this hypothesis.

Sufficient health from a relational egalitarian perspective

Compared to the ideal of a decent human life, I argue that the ideal of relational equality provides more ground to problematise inequalities in high income countries *as* insufficiencies. This is primarily because relational equality – which I understand in accordance with Anderson's approach of it – explicitly takes it as a demand of social justice that people can hold each other accountable for how they affect each other's lives. That is, inequalities should be in accordance with principles of justice that are 'interpersonally justifiable' (Anderson 2010a, 3).

The demand of interpersonal justification presupposes relations of equality, in the sense that if each person may hold others accountable for their actions, this assumes that people treat each other as equals. For instance, the chance to become a top athlete is substantially higher for some people than for others. These inequalities in opportunities are interpersonally justifiable if the last group is not impeded by others to develop one's athletic competences, and if people can live as free and equals without being best in sports. If both *would not* be the case, inequalities in opportunities to become a top athlete would be unjust from a relational egalitarian point of view.

Applied to inequalities in health, a relational egalitarian perspective implies that we should question whether existing health inequalities are in accordance with principles of justice that are interpersonally justifiable. This *might* come with an independent threshold for health. For instance, Daniels's defence of the protection of normal biological functioning as an interpersonally justifiable demand of justice entails the idea of a minimum threshold for health, as he argues that we are not entitled to *more* than the protection of normal biological functioning. That is, Daniels makes a principled distinction between 'treatment' and 'enhancement' and argues that justice as fairness demands treatment (and prevention) of pathology and that this should be given priority over enhancement (e.g. Daniels 2008, 149-157). However, this conception of a health minimum can be questioned, if only because a fundamental distinction between treatment and enhancement is hard to maintain (cf. Erler 2017).

Moreover, with the perspective of relational equality, we do not need an independent threshold for health to problematise socioeconomic health inequalities. Reflecting the above discussed approaches, there are two ways to evaluate whether people have sufficient health. Firstly, we can question the justifiability of the *causes* of health inequalities. That is, health inequalities are unjustifiable and thus unjust if they are for instance the result of relations of oppression or domination (cf. chapter 6), the result of inequality of concern by public health care institutions or by the state (cf. Kelleher 2016; Pogge 2006), or the result of unjustifiable socioeconomic inequalities (cf. Daniels et al. 1999; Peter 2001). Socioeconomic health inequalities may thus indicate that some groups are *insufficiently treated as equals*, for instance due to oppression or to neglect by the state. And so, the perspective of relational equality can problematise health inequalities indirectly as they may indicate that people fall short in terms of being treated and respected as an equal. Chapter 6 illustrates this by arguing that socioeconomic inequalities in health are especially a concern of justice if we consider the oppressive social structures by which these health inequalities are produced.

Secondly, relational equality confronts us also with the question of whether the inequalities are interpersonally justifiable given their consequences in a given society. To ask this question can also be considered as an indirect evaluation of health inequalities. That is, in case health inequalities have the effect of hindering people to function as equals, or make people vulnerable to oppressive relationships, they are unjust. As such, relational equality provides an alternative answer to the question of *what it is that people need to be sufficiently healthy for*.

The answer to that question discussed so far was ‘to live a decent human life’ as understood by Nussbaum. This ideal appeared to provide little guidance for what should count as enough since specific interpretations of the central human capabilities may differ per society and social and material circumstances interact with health and the latter’s effect on the quality of a person’s life. Besides, although Nussbaum explicitly rejects the negative sufficientarian claim that inequalities above the threshold are irrelevant for social justice (Nussbaum 2000, 125-126), she also admits offering a ‘partial theory of justice’ that does not tell us how to think of inequalities above a certain minimum (Nussbaum 2011, 40). Because Nussbaum is primarily concerned with countries that are low on the list of the Human Development Index, where conditions like infant mortality rates are high and healthcare services poor, her approach gives little clue for how to think of socioeconomic inequalities in health in countries like the Netherlands as an issue of social justice.

A relational egalitarian answer to the question what it is that people need to be sufficiently healthy for can be understood in line with Anderson's defence of the capabilities needed for 'democratic equality'. According to this ideal, everyone should be able to live on equal standing in public and political life and to function as an equal in the system of labour. This requires that people are sufficiently able to function as a person, and thus are healthy enough. But what counts as sufficient health depends on what one needs for other capabilities. Anderson for instance states that:

> *'negatively, people are entitled to whatever capabilities are necessary to enable them to avoid or escape entanglement in oppressive relationships. Positively, they are entitled to the capabilities necessary for functioning as an equal citizen in a democratic state.'* (Anderson 1999, 316)

And so, adopting this relational egalitarian perspective, the question is to see how poor health forms a barrier to the capabilities which Anderson mentions.

One may wonder what is exactly distinct between the ideal of relational equality and a decent human life. For while alternative, Anderson's view has much in common with Nussbaum's approach, since human dignity is a value at the heart of the ideal of relational equality, for which equal standing and being respected and treated as an equal are the central concerns (e.g. Anderson 1999; 2010a; 2010b). And vice versa, the ideal of relations of equality is encompassed by the ideal of a decent human life. For instance, Nussbaum's central human capability 'Control over one's environment' and the second part of 'Affiliation' together summarise the very social and relational concerns that have Anderson's – and with her, relational egalitarian's – focus:

> *'Affiliation: (…) B. Having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others. This entails protections against discrimination on the basis of race, sex, sexual orientation, religion, caste, ethnicity, or national origin. (...)*
> *Control over one's environment: A. Political. Being able to participate effectively in political choices that govern one's life; having the right of political*

> *participation, protections of free speech and association. B. Material. Being able to hold property (both land and movable goods); having the right to seek employment on an equal basis with others; having freedom from unwarranted search and seizure. In work, being able to work as a human being, exercising practical reason and entering into meaningful relationships of mutual recognition with other workers.'* (Nussbaum 1999, 235)

The central difference between Nussbaum's capability approach and Anderson's is thus the ideal or norm from which sufficiency levels of capabilities are derived: the ideal of 'a life in human dignity' and the ideal of 'relations of equality'. Arguably, the ideal of 'relations of equality' provides more guidance in the evaluation of socioeconomic health inequalities than 'a decent human life', partly because the absence of unequal or oppressive social relations is a more tangible criterion than the somewhat vague and abstract criterion of a decent human life.

But what is especially relevant for a concern with inequalities in health in high income countries, is that a focus on equal relations better enables us to problematise inequalities in health *as insufficiencies* than the ideal of a decent human life allows us to. Although Anderson does not include 'health' as one of the capabilities worth protecting (Anderson 1999, 318-319), her focus on protecting equal social relations and avoiding oppression, helps to see why also health inequalities in developed welfare states likely form a problem for social justice. For contrarily to what is sometimes suggested (e.g. Axelsen & Nielsen 2015; Powers & Faden 2006), health often functions as a positional good or has at least strong positional aspects. Firstly, a person's health is of instrumental value for what a person is able to be and do, and thus helps a person to uphold her position as an equal in society. Depending on how a society is organised, how healthy others are, may partly determine the value of one's own health, especially in the labour market. This is for instance salient when we consider the lower chances on employment by disabled persons compared to the 'able-bodied'. Secondly, to suffer from health problems generally entails that one is dependent on others, and so, to be less healthy than others makes one more vulnerable than others. Not only in a biological sense, but also socially, as health problems may in turn affect people's economic position. Inequalities in health between social groups can thus be a serious threat for relational equality, as it indicates that one group in society is significantly more dependent on others, and thus more vulnerable to oppression and domination. Again, to what extent this is the case ultimately depends on prevailing social norms, levels of technological development and existing social arrangements. And so, from the perspective of relational equality, inequalities in health *can* indicate insufficiencies in health, to the extent that they negatively affect people's capabilities to function on equal standing in society.

Conclusion

I have argued that while sufficiency is an appealing and well-defensible moral outlook for social justice, the task of determining minimal levels for health leads us away from direct evaluation, at least for the two routes that I have discussed. That is, if we take a health threshold to be given by what health levels are achievable in society, the normatively void notion of 'avoidability' becomes decisive for our judgments of justice. This leads us to the question of what health inequalities a society is due to avoid. When we use an external criterion or ideal from which we can derive what sufficient health entails, I have argued that we should consider how health interacts with social and material conditions to see what people are able to do and be given their health condition. This route leads us to evaluating the effects of health inequalities on people's capabilities.

In anticipation of the next chapters, I have argued how the ideal of relational equality enables us to problematise socioeconomic health inequalities *as* insufficiencies. That is, health inequalities may *indicate* that lower socioeconomic groups are oppressed or not treated as equals (chapter 6), as well as *threaten* lower socioeconomic groups' equal standing (chapter 7).

Notes

1. The worst-off could of course benefit from a redistribution of public health resources such that it primarily improves their health, rather than the health

of the best-off. But this would still not imply levelling down of the health of the best-off. This prioritarianism – giving priority to the worst-off – is notably defended by Parfit (1998) as an alternative to egalitarianism. The question of whether prioritarianism is preferable over sufficientarianism, I leave here undiscussed (see chapter 8; for a defence of a hybrid view endorsing both, see Crisp 2003). A challenge for both sufficientarianism and prioritarianism is that they in principle allow for the emergence of great inequalities. As I argue below and further elaborate in chapter 7, this is problematic but there is a form of sufficientarianism conceivable that puts constraints on inequalities in health.

2. Although, Venkatapuram declared to have changed his mind about this sufficientarian commitment (Conference 'Just Enough Health', Liverpool September 13, 2017).

3. I will here only consider health inequalities in terms of (healthy) life expectancy, which refers to the average health of groups, and thus to chances to health for individuals. Moreover, I do not exclude that when considering inequalities in terms of percentages of e.g. chronic disease prevalence, or prevalence of health in a broader sense such as in terms of psychosocial wellbeing, the question of threshold levels might be different (although also for prevalence of health problems, setting a non-arbitrary threshold is likely difficult as it demands a maximum of risks-level for the individual).

4. I do not dispute that this question is to be addressed in relation to a particular societal context (see chapter 6), but avoidability insuffices to serve as the only criterion for moral evaluation.

5. i.e. Life; Bodily health; Bodily integrity; Senses, imagination and thought; Emotions; Practical Reason; Affiliation (living with others & having the social basis of self-respect); Other species; Play; Control over one's environment (political & material) (see e.g. Nussbaum 1999, 235).

6. For a critical discussion of Nussbaum's methods of justification see Claassen & Düwell (2013).

7. The WHO defines healthy life expectancy as ‘average number of years that a person can expect to live in “full health” by taking into account years lived in less than full health due to disease and/or injury’ (WHO n.d.).

8. This reveals a fundamental difference between Nussbaum’s and Powers & Faden’s account. While having a lot in common with Nussbaum’s approach, Powers & Faden’s reliance on avoidability and context dependency for sufficiency levels suggests that they would argue that the threshold for health should be higher in developed welfare states than in developing low income countries.

9. Although – as chapter 6 shows – Daniels’s account could also be interpreted as a direct evaluative approach.

Chapter 6

Broadening the Rawlsian scope of justice to incorporate the complexity of the social determinants of health

Chapter 6 Broadening the Rawlsian scope of justice to incorporate the complexity of the social determinants of health

Introduction

Inequalities in health that correlate to inequalities in socioeconomic status, are generally thought to be unjust. If and why this is the case has been subject to debate, of which the starting point could be traced to Margaret Whitehead's 1990 paper. Whitehead proposed that if health inequalities are 'unnecessary' and 'avoidable', we should consider them to be unjust, unless they stem from freely chosen health-damaging behaviour (Whitehead 1990, 7). Another wording of a similar idea is that of health inequity as being dependent on 'policy amenability', meaning that health inequalities are unfair if they are 'due to factors amenable to policy' (Asada et al. 2015, 2).

It is not hard to see how this criterion of avoidability can be philosophically problematised: in principle, *any* (socially caused) inequalities in health could be avoided, if we would want to. But this would come at costs that no one would likely be willing to pay. For instance, we can avoid health inequalities if we would bring down the health of the best-off. Also, some health inequalities could be avoided if we would be willing to give up values like autonomy and privacy, by fully controlling people's nutritional intake and other behaviours that may damage health.[1] The later added clause by the WHO, that inequalities should be avoidable 'by reasonable means' (e.g. WHO 2014), only helps to see that these are obviously not the scenarios foreseen, yet it still leaves us with the question of what is 'reasonable'.[2]

In this chapter, I address the question of to what extent the account by Norman Daniels helps us to specify which health inequalities are avoidable by reasonable means. That is, which health inequalities should be avoided for reasons of justice? Daniels's approach as elaborated in Just Health seems to offer a way to do so by defining what is reasonable in reference to Rawls's principles of justice as fairness. After briefly explaining what this 'indirect' evaluative approach entails according to Daniels's account, I show that indirect evaluation of socioeconomic health inequalities with the help of Rawls's principles is an unsatisfactory route. For given Rawls's understanding of society's basic structure, these principles of justice as fairness cannot adequately capture the complexity of the social determinants of health. While Daniels's account is unclear about how it understands the scope of the basic structure, I argue that for a wholehearted concern with socioeconomic health inequalities while giving due consideration to how exactly they emerge, we should broaden that scope beyond basic institutions. For this reason, I propose to understand society's basic structure in accordance with Iris Young's notion of social structural processes and health inequalities as structural injustices. With this perspective, we can better acknowledge health inequalities as being part of and constitutive to the oppressed position of lower socioeconomic groups. It thereby appears that specifying which health inequalities are unjust and avoidable becomes a question of collective responsibility.

I. Rawlsian indirect evaluation

Daniels's proposal for indirectly evaluating socioeconomic health inequalities

In 'Why justice is good for our health. The social determinants of health inequalities', Daniels, Kennedy and Kawachi (1999) address the question of whether all inequalities in health are unjust if they stem from socioeconomic inequalities. The problem the authors address is that there is a strong association between socioeconomic position and health, and that, theoretically, we could erase these socioeconomic health inequalities by eliminating all socioeconomic inequalities. However, while equal health levels might seem a demand of social justice, strict equality in socioeconomic terms is not. Therefore, in this 1999-paper, as well as in his book Just Health, Daniels proposes to ground the distinction between just and unjust health inequalities in Rawls's theory of justice as fairness, as the latter tells us what is just in socioeconomic respect.

Daniels thereby nevertheless adjusts Rawls's theory, because Rawls treats health as a natural good – as opposed to social goods – and therefore not as a concern for a theory of justice (e.g. Rawls 1999, 54). Daniels argues that health importantly contributes to our opportunity range, and that we therefore need to protect people's health needs, which he takes to include things like adequate nutrition, safe and unpolluted living and working conditions, and various medical services. Besides, Daniels mentions 'the appropriate distribution of the social determinants of health' (Daniels 2008, 43-44) as a health need. Daniels understands Rawls's principles of justice as fairness as regulating an 'appropriate distribution' of these social determinants. And so, the point of evaluating health inequalities is to assess whether they occur in a society with equal basic freedoms and political rights, fair equality of opportunity, and where social and economic inequalities significantly benefit the worst-off (e.g. Rawls 1999, 52). Daniels thereby proposes so-called 'indirect' evaluation, meaning that we evaluate health inequalities to be just or unjust by deriving our judgement from how we evaluate the distribution of their socioeconomic determinants, rather than 'directly' evaluating health inequalities as a self-standing moral issue (Peter 2001).[3]

As Daniels notes, the three indicators of socioeconomic position (and as such three major determinants of health) – income, education and occupation – are indeed importantly affected by the principles of justice as fairness. For instance, the distribution of income and wealth is supposed to be regulated by the difference principle, which only allows for economic inequalities if they benefit the worst-off, e.g. by taxes and market regulations. And the principle of fair equality of opportunity regulates inequalities in education level, as it aims to guarantee that education is accessible for people with equal talents and motivations, e.g. by distributing public funding for schools fairly, prohibiting discrimination by schools, by obligating education until a certain age, etc. Also regarding 'occupation', the principle of fair equality of opportunity aspires for occupations and functions to be accessible for each with equal talents and motivations, e.g. by prohibiting discrimination by employers, and prescribing rules for fair application procedures in general. And so, Daniels concludes that:

> *'Rawls's principles of justice as fairness regulate the distribution of the key social determinants of health (...) Properly understood, justice as fairness tells us what justice requires in distributing all social determinants of health.'* (Daniels 2008, 97)

However, the conclusion that Rawls's principles of justice regulate the distribution of the key social determinants of health is not entirely accurate. For Rawls's understanding of the primary subject of justice – society's 'basic structure' – is too narrow to be conceived of as entailing 'the key determinants of health'.

According to Rawls, to take the basic structure of society as the primary subject of justice means that the principles of justice as fairness only regard:

> *'the way in which the major social institutions distribute fundamental rights and duties and determine the division of advantages from social cooperation. By major institutions I understand the political constitution and the principal economic and social arrangements. Thus, the legal protection of freedom of thought and liberty of conscience, competitive markets, private property in the means of production, and the monogamous family are examples of major social institutions.'* (Rawls 1996, 6).[4]

So, the principles of justice as fairness regulate, or apply to society's basic institutions. It is thereby not evident how to understand the distinction between 'basic' (or 'major') and 'non-basic' institutions, as Rawls's theory does not explain how exactly the principles 'apply' differently to basic institutions than to other actors (Chambers 2013). Nevertheless, Rawls clearly does not think that the principles of justice as fairness regulate society at the level of actions by e.g. individuals, churches, schools, or firms, except from constraining their acts (e.g. Rawls 1985, 245; Rawls 2001, chapter 1). Rawls states for instance that his 'account of the institutions of property-owning democracy has not considered the importance of democracy in the workplace and in shaping the general course of the economy' (Rawls 2001, 178). Even though democracy at the workplace would contribute to justice as fairness, Rawls does not take it as a requirement of justice. But, as also Daniels (2008,

96) acknowledges, if we are to be concerned with health inequalities, we should not ignore the workplace as a social determinant of health. When taking further into account what we know from epidemiological studies, the question arises of what more social determinants we should be concerned with and how to relate this to the idea that society's basic structure is the primary subject of justice. Before I address that question, I will briefly discuss how socioeconomic health inequalities are explained by epidemiologists, and how this cannot be adequately captured by a theory of justice that assumes a Rawlsian basic structure.

The complexity of the social determinants of health

Considering studies in epidemiology, it appears that a great part of the social determinants of health are hard to understand as part of the basic structure as conceived of by Rawls. Moreover, these studies show that we cannot assume that there are clear causal relationships between what Daniels calls 'key social determinants' and health. Rather, we may interpret epidemiological findings as indicating what Sheehan (2006) has called 'the social reality of health'.

To start with this last point, indirect evaluation – as proposed by Daniels – assumes a common conceptual distinction made in the empirical literature between so-called 'upstream' and 'downstream' determinants (e.g. Daniels et al. 1999; Asada 2007; Braveman et al. 2011). Downstream determinants refer to the material, behavioural and psychosocial factors, such as air pollution, smoking and stress, that (almost) immediately cause health problems. Upstream determinants refer to 'social arrangements that determine the health achievement of societies' (Daniels et al. 1999, 216) or 'the causes that reflect the social structure' (Asada 2007, 14), such as the distribution of income and education level. According to this view, upstream factors 'fundamentally shape' downstream determinants (Braveman et al. 2011), which in their turn determine people's health.

But considering the diversity of downstream determinants – e.g. housing conditions, physical working conditions, nutritional habits, smoking, social support (Van Lenthe et al. 2004) – we can imagine that if and to what extent a low income or a low education level correlates with ill health all depends on how strongly the former lead to the material, behavioural, and psychosocial factors that harm people's health, and that there are many contextual variables that may disturb the causal picture assumed by the proposal for indirect evaluation. That is, by supposing that a fair distribution of income and wealth, education and occupation constrains health disparities, such contextual variables are overlooked.

Recent developments in epidemiologic thinking challenge the metaphor of upstream and downstream determinants further, by adopting 'complex systems'-analysis. Applying a complex system approach to issues of population health, means that health is understood as a manifestation of a system in which biology, environments and individuals interact with each other over time. As such, epidemiology entails studying how genes, social norms, environmental structures and behaviour influence each other, rather than tracking the causal pathways of these factors in isolation from each other (Diez Roux 2011). This is for example how Diez Roux (2011) depicts the ways in which socioeconomic inequalities in health likely arise:

> *'Parental socioeconomic circumstances may affect both the health and educational achievement of children. Childhood health also has consequences for educational achievement and socioeconomic circumstances later in life, which, in turn, has consequences for the health and educational achievement of the next generation. Parental socioeconomic circumstances may also shape exposure to peer groups, which could affect offspring's educational and health outcomes through social influences. Reinforcing feedback loops between health and socioeconomic factors (…) and between peer characteristics and offspring characteristics (…) further complicate these relations.'* (Diez Roux 2011, 1630)

The point of a complex system approach is to acknowledge the absence of clear predictable parameters, by examining 'feedbacks, interrelations among agents and discontinuous non-linear relations' (Galea et al. 2010, 99). This means that outcomes in health can at the same time be determinants of health. And although it is primarily socioeconomic position that determines health, health outcomes can also be determinants of socioeconomic position. For instance, obesity might be caused by little exercise, it may itself also be a determinant of individual exercise patterns if the overweight comes with shame – induced by social norms – and thereby prevents people to go out. Also, being overweight may hinder a person in various ways to find work.

Complex system approaches further show that factors playing a key role in determining health do not stand on their own: dietary habits are e.g. shaped by social networks, and by neighbourhood-features such as the availability of healthy food and walking areas. Importantly, complex system thinking can account for the persistence of health inequalities over generations, as it considers the role of parental circumstances, and childhood development.

Changing 'upstream' factors, may thus not linearly lead to a change in 'downstream' factors. For example, earning a higher income may not change nutritional habits, or take away a lack of social support. Moreover, attempts to reduce health inequalities by interventions on 'downstream' level may not automatically lead to a change in health outcomes. For instance, access to healthy food may be overruled by adversary social norms about eating; and stimulating exercise by providing more footpaths may remain ineffective if these paths are situated in areas with persuasive advertisements for fast-food.

It thus appears that we cannot simply assume that a just basic structure can be relied upon to do the work for keeping the socioeconomic gap in health small: many more social factors are at work that go beyond the basic institutions that are subject to Rawls's principles of justice as fairness.

Broadening Rawls's opportunity principle

We can now see that socioeconomic health inequalities appear to be determined by conditions and actors that cannot be captured by focusing on the basic structure as conceived of by Rawls's theory of justice. And that the claim that Rawls's principles of justice regulate the 'key social determinants of health' is therefore inaccurate. However, as already hinted at in note 3, perhaps there is a way in which Rawls's principles *can* regulate the key social determinants of health. For according to Daniels, we should broaden Rawls's principle of fair equality of opportunity. This starts by Daniels's understanding of 'health' in accordance with Boorse's theory of health as normal biological functioning, that is, as being free from pathology. This biomedical concept of health is supposed to identify 'objectively ascribable' health needs (Daniels 2008, 34). Daniels argues that health needs should be met, because normal biological functioning contributes to our opportunities, and thus to fair equality of opportunity.[5]

For Rawls, fair equality of opportunity demands that persons with the same talents and willingness to use them have equal opportunities in the system of social cooperation, i.e. opportunities to jobs, careers and political positions (e.g. Rawls 1999, 76). We can easily see that not *all* derivations from normal biological functioning have a negative impact on a person's economic opportunities, nor on his or her political freedoms. Daniels himself mentions the example of being infertile. Although a clear case of a Boorsian dysfunction, infertility is not a pathology that hinders people to work or study, or to participate in political life. Yet, infertility does interfere

> *'with other basic functionings of free and equal citizens, such as reproducing themselves biologically, an aspect of plans of life reasonable people commonly pursue'* (Daniels 2008, 59)

Finding Rawls's opportunity focus too narrow, Daniels broadens the principle of fair equality of opportunity in the system of social cooperation, to the principle that each person should have a fair share of

> *'the normal opportunity range, that is, the array of life plans persons can reasonably choose in a given society'* (Daniels 2008, 59)

According to Daniels, each person's fair share of this normal opportunity range should be protected, because having a normal opportunity range to pursue life plans is of 'fundamental interest' to us.[6] As he argues:

> *'impairments of normal functioning reduce the range of exercisable opportunities from which individuals may construct their "plans of life" or "conceptions of the good" (…) In sum, there is wide agreement on the importance of meeting needs required for normal functioning because people*

> *have a fundamental interest in maintaining a normal range of opportunities.'* (Daniels 2008, 35-36)

So, for Daniels, the demand of equality of opportunity in this broadened sense is met when neither socioeconomic conditions, nor pathologies, impact one's opportunities to pursue life plans. And so, it becomes a demand of justice to protect normal biological functioning, as this is taken to be 'one clear parameter' (Daniels 2008, 44) of having a normal opportunity range. But what the demand to protect a normal opportunity range *exactly* means remains unclear. On the one hand, Daniels endorses Rawls's understanding of the basic structure as a set of basic institutions, when he argues that the basic structure should be extended by also seeing healthcare institutions as 'basic institutions' (Daniels 2008, 57). This suggests that the protection of normal functioning should merely be taken care of by basic institutions. On the other hand, Daniels acknowledges that health is importantly influenced by actors that do not belong to the basic structure as originally conceived of by Rawls, as he argues:

> *'Suppose that, as Marmot (2004) argues, structural and organizational features of the workplace that induce stress and loss of control tend to promote health inequalities. If this is true, then those features should be modified to reduce their negative effects on health as a public health requirement of the equal opportunity approach.'* (Daniels 2008, 96; cf. Daniels et al. 1999, 231-232)

As noted above, Rawls deliberately does not take the workplace as part of society's basic structure. And so, Daniels's account remains unclear about the question of to what extent it departs from Rawls and his understanding of the basic structure as a set of basic institutions. However, to take seriously the broadened opportunity principle's demand to protect health, requires a substantial broadening of Rawls's notion of society's basic structure, such that other domains and actors that affect health, like employers and the workplace, can be understood as being subject to judgements of justice.

II. Socioeconomic health inequalities as structural injustices

The social determinants of health as social structural processes

Considering what we know about the social determinants of health, we may question whether all these determinants *should* be seen as belonging to the subject of social justice. For while factors playing a role in the emergence of health inequalities – e.g. social norms, family habits, physical environments – are no 'facts of nature', they cannot be judged like we judge unequal distributions of material goods, or intentionally harmful acts. One might even conclude that confronted with such complexities, theories of justice leave us empty-handed and make us retreat in fatalistic silence. At the same time such silence may imply a fierce denial of the moral intuitions of many when confronted with the persistent gaps in healthy life expectancy between different social groups.

Although moral intuitions can give us some initial guidance, we would not want them to be our only source of evaluation: some normativity is due to take a critical stance towards our initial judgments and to prevent dogmatism. To understand the social mechanisms leading to health inequalities as subject to judgements of justice, the work by Iris Young and her notion of 'structural injustice' is helpful. By critically engaging with Rawls's concept of the basic structure, her approach can take into account the full complexity that marks the social determinants of health. And, while not offering full principles of justice, it does provide a normative perspective, which helps to distinguish just from unjust inequalities.

Although Young agrees with Rawls that formal institutions are necessary means to promote social justice, she points out that the greater part of social injustices are produced by 'everyday social conventions, practices, and habits that individuals enact and reenact' (Young 2011, 70). She argues that Rawls's talk of structure mistakenly suggests that the primary subject of justice is 'a part of society, a small subset of its institutions, that is more fundamental than its other parts' (Young 2011, 70). According to Young, there is no relevant way to single out one isolated basic structure, since institutions and the injustices in which they are involved do not stand on their own: they are constituted by the (inter)actions of many people, which are structured by habits, social norms, beliefs and material environments.

Yet, Young also concurs with Rawls that the primary subject of social justice should be the background conditions of a society and its unintended effects. And so, she reconceptualises the notion of structure, by drawing on sociological theory. Rather than understanding the primary subject of justice as a static basic structure, Young argues that we should understand it as 'social-structural processes' (Young 2011, 53). She does not provide a straightforward definition but describes social-structural processes as manifesting themselves in four ways:

> *'(1) as objective social facts experienced by individuals as constraining and enabling; (2) as a macro social space in which positions are related to one another; (3) as existing, however, only in actions; and (4) as commonly involving the unintended consequences of the combination of the actions of many people.'* (Young 2011, 53)

I will not discuss these aspects in detail, as I just aim to show that Young's broader understanding of society's structure provides a way to capture the complexity of the social determinants of health, while considering them as (potentially) raising issues of social justice. That is, by recognising that the everyday actions of many agents – structured by formal institutions, policies, cultural values, material environments, habits, social norms and rules, etc. – can produce social injustice, the notion of social-structural processes allows us to include the above discussed complex pathways to health inequalities as being subject to judgments of justice.

Structural injustice

But when should we judge unequal outcomes of these social structural processes to be *unjust* – and thus as inequalities to be acted upon? According to Young, we may speak of 'structural injustice' if structural social processes

> *'put large groups of persons under systematic threat of domination or deprivation of the means to develop and exercise their capacities'* (Young 2011, 52)

So, according to this explanation by Young, inequalities are unjust if they are the result of social-structural processes *and* entail domination or deprivation of the means to develop and exercise capacities. By domination, Young understands the inability to determine one's own actions or the conditions of one's actions (e.g. Young 1990, 31-32). The idea that people should be able to develop and exercise their capacities is also referred to by Young as the absence of oppression. Young has characterised oppression as knowable by 'five faces': that of exploitation, marginalisation, powerlessness, cultural imperialism and violence (Young 1990, chapter 2).

By taking domination and these five forms of oppression as central characteristics of social injustice, Young's view highlights the moral importance of addressing situations in which advantages of the more powerful and better-off come at the cost of the less powerful and less well-off. As such, Young's work strongly resonates an idea at the heart of Rawls's theory of justice, namely the ideal of democratic equality which makes Rawls adopt the difference principle (e.g. Rawls 1999, §13). However, whereas Rawls difference principle is primarily concerned with (re)distributions, Young has emphasised the importance of a concern with the processes that lead to distribution patterns (e.g. Young 1990, chapter 1; 2006). In what follows, I discuss what Young's understanding of structural injustice implies for the evaluation of socioeconomic health inequalities.

Socioeconomic inequalities as structural injustices

Young's discussion of contemporary welfare states provides several examples of how lower socioeconomic groups are vulnerable to various forms of oppression and domination (e.g. Young 1990, chapter 2 and 3). And as such her account offers an indirect way to judge socioeconomic health inequalities as unjust, in the sense that the inequalities related to health inequalities are unjust. We may consider for instance how Young queries today's division of labour:

> *'How shall we evaluate morally the structure of the occupational distinctions, the definition of tasks within them, and the relations among people occupying differing positions within a production, distribution, or service enterprise? Is it just, for example, that an aspect of the basic structure of society consists in an occupational pyramid where the more plentiful positions at the bottom are relatively menial, repetitive, and subordinate to the decisions of others, while the few positions at the top carry broad autonomy, decision making power, and prestige?'* (Young 2006a, 93)

From Young's perspective, working with little or no job autonomy entails a form of domination, as workers can hardly, or not at all, determine the course of their own actions (cf. Anderson 2015).[7] And so, that part of socioeconomic health inequalities that are associated with a lack of autonomy in the workplace can be derivatively judged to be unjust. Similarly, we may consider how lower socioeconomic groups are oppressed in the sense of being (at risk of being) exploited, for instance if the work they do is not sufficiently compensated for (cf. Young 1990, 49-50). Or how these groups are (at risk of being) marginalised, for instance by being subjected to the 'often arbitrary and invasive authority of social service providers' (Young 1990, 54). To the extent that lower socioeconomic groups experience these specific forms of oppression, we can thus indirectly judge socioeconomic health inequalities to be unjust.

But such derivative judgments may be missing the point. For as shown by discussing epidemiological explanations, poor health is not simply a 'side-effect' of inequalities in income and education level but is instead very much entangled with, and partly constituting the very social position of lower socioeconomic groups. As I have argued, we can think of the social mechanisms that produce socioeconomic inequalities in health as the very social structural processes that Young has in mind when talking about structural injustice. This gives rise to the question of whether we may more 'directly' judge socioeconomic health inequalities to be unjust.

While the condition of being in poor health *as such* may not be a condition of oppression, this is different when lower health levels come with – and are often entangled with – other disadvantages. To this, Young's discussion of the relevance of comparing groups is illuminating. Young (2001) argues that comparing groups by various measures of wellbeing and social status is important to identify structural inequalities, and eventually structural injustices. Regarding the question as to when to judge structural *inequalities* to be structural injustices, she says:

> *'We must discover that such inequality [between groups] is systemic by finding a pattern of average differences in level of status or wellbeing along several parameters. (…) We are not warranted in the full evaluation, unless we can tell a plausible structural story that accounts for the production of the patterns. To complete the analysis and evaluation, we must explain how institutional rules and policies, individual actions and interactions, and the cumulative effect and often unintended material effects of these relations reinforce one another in ways that restrict the opportunities of some to achieve well-being in the respects measured, while it does not restrict so that of the others to whom they are compared, or even enlarge their opportunities. This story will be aided, moreover, by evidence that the basic configuration of the patterns shows little change over decades.'* (Young 2001, 16)

By taking health as one parameter of wellbeing, we can apply this reasoning to socioeconomic health inequalities. Firstly, to be unjust, health inequalities must intersect with other inequalities in social status or wellbeing – such as in income and/or education level. Secondly, health inequalities must be demonstrated to be the result of social structural processes. As noted above, complex system thinking in epidemiology shows they are: being in a lower socioeconomic position leads to health deprivations via physical environments, habits, social norms and institutional arrangements. Although a great part of socioeconomic health inequalities is related to behaviour, framing this as a matter of individual choices would misrecognise that behavioural patterns are formed by social norms and rules, as well as by material conditions such as wealth and environment. And so, we can think of these health inequalities as being 'mediated by structurally induced differences in behaviour' (Barry 2005, 74). Contrarily to socioeconomic health inequalities, there is probably no structural story to tell for health inequalities between different age groups, in so far biological rather than social processes account for the health problems that come with aging. Lastly, Young mentions that inequalities are more likely to be unjust if they are persistent over generations. The reason for this is that the way a society is culturally and institutionally organised, is itself persistent, and we may thus take persistent inequalities as a proof of their being structural. This intergenerational persistence certainly holds for socioeconomic health inequalities, that are not only known to exist since ages (cf. Mackenbach 1995) but are also explained by the influence of the social position of parents on their children's health (e.g. Diez Roux 2011).

And so, we can understand socioeconomic health inequalities as structural injustices, because health is an important parameter of wellbeing that intersects with other, persistent disadvantages, and because we can explain these health inequalities as resulting from social structural processes.

III. Back to the question of avoidability and health equity

Taking socioeconomic health inequalities as structural injustices assents to the definition of health equity as defended by Braveman & Gruskin (2003):

> *'the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy'* (Braveman & Gruskin 2003, 254)

The group-aspect is also adopted – in addition to the avoidability criterion – by the WHO, stating that 'Systematic differences in health between social groups that are avoidable by reasonable means are unfair' (WHO 2014, xiv). Young's theory of structural injustice tells us that this understanding of health equity is justified *only* if we can explain the emergence of group inequalities by social-structural processes. I have argued that we can.

Compared to Daniels's approach, with Young's perspective we can better account for the complexities of the social mechanisms that lead to socioeconomic health inequalities, but pressing questions remain unresolved.

Perhaps most pressing is the question of whether the category of unjust health inequalities does not become too comprehensive. That is, by broadening the understanding of society's basic structure the categories of inequalities due to 'bad luck' as well as to 'individual free choice' become small, if not non-existent. Regarding bad luck, we may indeed conclude that this term should be reserved for individual and incidental misfortune. In terms of health, we may for instance think of diseases that are purely or primarily due to biological mutations, such as various cancers.[8] We should thereby note that as soon as we come to speak of socioeconomic inequalities in health we come to speak of inequalities between groups, such that individual misfortune disappears. That is, as far as misfortunes occur much more often in lower socioeconomic groups, it is difficult to call this 'misfortune'. And so, the category of 'bad luck' may not be that relevant for the evaluation of socioeconomic health inequalities.

Regarding the question of individual free choice, we may question whether all health problems stemming from health-damaging behaviours are unjust, also if these behaviours are structurally induced. For what if people in lower socioeconomic groups do not want to exercise and eat healthy food in order to have a BMI of 20? Or what if people of lower socioeconomic groups prefer a shorter life with more short-term pleasures to a long life with long term pleasures? To what extent should we understand such wants as 'authentic'? These are tough moral questions, answers to which require a discussion of issues such as agency versus structure, and the role of adaptive preferences. Although I cannot do justice to these issues here, I close off by sketching some further directions of thought. Following Young, a key question for the justness of health inequalities remains as to what extent we can explain these behaviours as the result of the social position people find themselves in. That is, to what extent is it plausible to say that people are 'forced' to make choices that are less optimal for their health? As with bad luck, it seems hard to maintain that unhealthy behaviours are freely chosen, if they occur significantly more often in lower socioeconomic groups. Although not discussed by Young, we may subsequently try to discern degrees of the oppressiveness of such forces. For instance, if pressure for unhealthy eating comes from family habits, or from community members, we may think of this pressure as easier to resist than when a lack of income constrains one's choices. Of course, things are generally not that clear-cut, and especially on population level, it is almost impossible to distinguish such degrees. For this reason, Blacksher (2018, 13) may be right in noting that 'firm conclusions about individual responsibility are best not drawn from epidemiological data'. Especially if ascribing responsibility to individuals comes with a sense of blameworthiness, the risk of blaming the victim may be deemed to be too big.[9]

A second, much-related question that needs to be addressed is to what extent we can still think of socioeconomic health inequalities as 'avoidable'? Identifying the origin of health inequalities in social structural process makes them *in principle* avoidable, in the sense of 'preventable' (cf. Preda & Voigt 2015). However, this is not at all to say that they are *easy* to avoid. In fact, we may wonder whether the demand to reduce socioeconomic health inequalities does not leave us with an unsurmountable task, considering the persistency and interlinkages of health with socioeconomic positions. Indeed, changing social structural processes *is* an insurmountable task if the change is expected to come from single individuals, and not backed by influential actors, like (semi-) governments and corporations. From Young's perspective, the point is to look at our collective ('political') responsibility to reduce structural inequalities in health, since we all – in different degrees – partake in the reproduction of the relevant social structures. And so, the question of 'avoidability by reasonable means' (WHO 2014, xiv), comes down to the political question of what we can reasonably expect – in terms of diminishing structurally produced health deprivations – from the side of individuals, communities, employers, schools, corporations, governments and whatever other actors influence people's health.

IV. From ideal to non-ideal theory

Before I conclude, some meta-theoretical comments should be made. For one may note that the analysis above can also be explained as a discussion about ideal/non-ideal theory: by substituting Rawls's basic structure with Young's social structural processes, we shift from 'ideal' to 'non-ideal' theory. That is, Rawls pursues ideal theory, by making idealising assumptions about how individuals and associations or non-basic institutions behave. He brackets the question of how the latter should act, in order to focus on the on the for him *fundamental* question of what principles of justice would be endorsed by citizens if they would think of what a perfectly just society looks like. So, in ideal theory:

> *'[e]veryone is* presumed *to act justly, and to do his part in upholding just institutions'* (Rawls 1999, 8, my emphasis)

By explicitly acknowledging that this assumption is an idealisation, ideal theory acknowledges that in the real world, people do not strictly act in accordance with the principles of justice as fairness, implying that real-world inequalities are hardly ever perfectly just. Rawls may for instance well recognise that even though we all agree that discrimination is unjust, many of our actions are based on prejudice which results into implicit discrimination in the education system and the labour market.

Young's project is non-ideal in the sense that she does not theorise what a perfectly just society would look like, but how to act upon real world injustices. She acknowledges how actors behave in the real world, by providing a reconceptualisation of society's structure that is aligned with how the social world actually works. Besides, by developing the idea of political responsibility, Young focuses on the question of how to make the world more just, a question that characterises non-ideal theory (cf. Robeyns 2008).

Daniels's position is somewhat difficult to pinpoint in terms of ideal and non-ideal theory. As with individual behaviour, Rawls's theory makes idealising assumptions regarding health by assuming that everyone lives a life in good health (e.g. Rawls 1999, 83-84). And so, Daniels makes a move towards non-ideal theory by developing Rawls's theory further to cope with real world issues such as socioeconomic health inequalities, as well as by proposing that the social determinants of health should be addressed to counter social inequalities in health. At the same time, Daniels aims to do so by broadening, though preserving, Rawls's ideal principles of justice, and does not clarify to what extent he drops the idealising assumption that people act in accordance with the principles of justice.

This ambiguity regarding ideal and non-ideal theorising in Daniels's theory may explain why we can read in Daniels's account both a proposal for direct and for indirect evaluation (see note 3). For in fact, by shifting towards non-ideal theory, the distinction between direct and indirect evaluation dissolves. That is, in line with direct evaluation, Daniels's broadened opportunity principle considers inequalities in health as a moral concern. However, in so far as Daniels thinks that the justness of the distribution of health depends on the distribution of e.g. income and political liberties he does not take health inequalities as being of independent moral concern and proposes indirect evaluation.

If we take the non-ideal approach by considering socioeconomic health inequalities as structural injustices in Young's sense, the distinction between direct and indirect evaluation becomes even more blurred. For also with Young's perspective, health inequalities are a moral concern, but not an independent moral concern: we can only speak of structural injustice if several inequalities in wellbeing and/or social status intersect with each other and that are induced by social structural processes. Moreover, with Young's notion of structural injustices we can capture the complex entanglement of health and other (socioeconomic) disadvantages. As such, both evaluating the justness of the distribution of the social determinants of health in isolation from health patterns and evaluating health patterns in isolation from their social determinants appear to become almost unintelligible.

Conclusion

This chapter started with the observation that taking 'avoidable' health inequalities as 'unjust' health inequalities is philosophically problematic, and the question to what extent Daniels's account helps to specify which health inequalities *should* be avoided for reasons of justice. I argued that answering this question in reference to Rawls's principles of justice as fairness is unsatisfactory, because Rawls's principles only regard society's basic institutions. As such, they do not regulate social determinants of health that do *not* belong to the basic structure and thus only partly tell us which inequalities are avoidable.

By replacing a Rawlsian understanding of society's basic structure with Young's notion of social structural processes, we can acknowledge how socioeconomic health inequalities are constituted by the interactions of numerous individual and institutional actors. Rather than understanding health deprivations as the side-effect of an unjust basic structure, I have argued that we should understand them as being entangled with – and as partly constituting – the oppressed positions of lower socioeconomic groups.

This renders the question of avoidable health inequalities into a question of social responsibility, which is after all very much in line with what policy documents by e.g. the WHO advocate. Where to draw lines between social and individual responsibility ultimately depends on whether there is a structural story to tell about the unequal prevalence of health problems, like we can for socioeconomic health inequalities. And on what we can reasonably expect from the actors that uphold the social structures that give rise to these inequalities, to prevent health damaging behaviours. To discuss these questions adequately, a non-ideal approach is crucial, such that knowledge of the social mechanisms leading to health inequalities can be accounted for.

Notes

1. For an impression of what a society in which disease prevention is the highest imperative would be like, see Juli Zeh's *Corpus Delicti* (2009)

2. For a critical discussion of the avoidability criterion, see Preda & Voigt (2015) and the comments on their paper in the *American Journal of Bioethics* Vol. 15(3).

3. Because Daniels broadens the opportunity principle, his account can also be interpreted as entailing a proposal for direct evaluation (e.g. Anand & Peter 2000; Wilson 2011). I will come back to this reading below, but first discuss Daniels's account as advocating an indirect evaluative approach, because this

could help to morally demarcate the category of avoidable health inequalities. See for a similar, though less elaborate, proposal for indirect evaluation by Rawls's theory of justice Peter (2001). See Wester (2018) for a more general defence of indirect evaluation.

4. Elsewhere, Rawls defines it as 'a public system of rules defining a scheme of activities that leads men to act together so as to produce a greater sum of benefits and assigns to each certain recognized claims to a share in the proceeds.' (Rawls 1999, 74).

5. In fact, Daniels makes the (much) disputed claim that health in the sense of normal biological functioning is 'morally special'. While this claim is problematic (see e.g. Wilson 2009; Nielsen 2015), we can still follow Daniels's argument as stating that being healthy 'significantly' contributes – besides other things – to what we are able to be and do (Daniels 2009, 37

6. The idea that a normal opportunity range is of *fundamental* interest to us is dubitable too (cf. Schramme 2009) and brings in a form of moral relativism that one may object to (cf. Venkatapuram 2011). Again, I will sidestep that issue here and agree with Daniels's more modest claim that being free from diseases importantly contributes to the range of beings and doings that we are able to pursue.

7. Although this passage also strongly resonates her earlier description of the powerlessness of nonprofessional workers: 'the powerless are situated so that they must take orders and rarely have the right to give them (...) The powerless have little or no job autonomy' (Young 1990, 56).

8. Arguably, considering expanding pathogenetic and epigenetic knowledge, the category of 'bad luck diseases' deserves further discussion.

9. In fact, this is a concern that Young's account *enables* us to put forward, as it considers the very oppressive effects of social norms about healthy behaviour. And so, Young's perspective actually shows that there are *two* questions to be answered in relation to health inequalities stemming from health damaging behaviours. Firstly, when do social structural processes force people to live unhealthy? And secondly, when are policies and interventions to steer groups to behave healthier in itself oppressive?

Chapter 7

Why socioeconomic inequalities in health threaten relational justice. A proposal for an instrumental evaluation

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Chapter 7 Why socioeconomic inequalities in health threaten relational justice. A proposal for an instrumental evaluation

Introduction

A large amount of epidemiological literature shows the persistence of inequalities in health within countries among people with different socioeconomic status. Notably, the two longitudinal Whitehall Studies have found a systematic correlation between the employment grades of civil servants and disease prevalence and mortality rates (e.g. Smith et al. 1990). This reveals what is known as the 'social gradient in health': the lower in the hierarchy of social stratification, the higher disease prevalence for various (chronic) diseases and thus the higher mortality rates. Since the first Whitehall Study, many more studies confirmed the relation between (healthy) life expectancy and socioeconomic status, generally indicated by occupational, income, or educational level (Hatzenbuehler et al. 2013; Marmot & Wilkinson 1999; Marmot 2017).

For a few decades, reducing socioeconomic inequalities in health has been on the agenda of policymakers (e.g. Mackenbach & Stronks 2002). One motivation for tackling health inequalities may be that public investments should be made where the most health gains can be made. The intuition that these systematic inequalities in health are unjust, is arguably another.

Thus far, the question of why these inequalities in health are unjust, has been primarily answered by judging the unjust distribution of the 'causes of the causes', i.e. their social determinants (e.g. Daniels et al. 1999; Daniels 2008; Whitehead 1990). This focus on causes is indispensable for our moral evaluation. For instance, it seems morally relevant to know to what extent health inequalities are the result of deliberately chosen behaviour (e.g. Stronks & Gunning-Schepers 1992). Also, if health inequalities stem from other social injustices, such as unfair inequalities in (access to) income, this should play an important role in our explanation of why they are unjust (e.g. Daniels 2008).

Yet focussing *merely* on causes leaves out of sight the injustices that potentially *result* from health inequalities. This blind spot deserves more attention, given that socioeconomic inequalities in health are persistent, and have proven to be very hard to reduce (e.g. Link & Phelan 1995; Mackenbach et al. 2017). In this chapter, we thus first argue that in addition to an evaluation of the causes, an evaluation of the consequences of health inequalities is due, calling this 'instrumental' evaluation. We thereby adopt relational egalitarianism as our evaluative framework, following earlier explorations of the merits of this approach for our thinking about health and justice (e.g. Kelleher 2016; Pogge 2006; Voigt & Wester 2015). Kelleher (2016) and Pogge (2006) have shown how relational egalitarianism could be a fruitful framework to problematise (socioeconomic) health inequalities based on their causes, but our focus here will be the evaluation based on their consequences.

Considering the potentially negative effects of health inequalities on relational equality contributes to a completer story of why systematic inequalities in health are unjust. Based on the literature on the effects of poor health, we illustrate this by discussing three examples of how socioeconomic inequalities in health evidently threaten the ideal of relational equality: unequal risks of stigmatisation, unequal risks of unemployment, and unequal chances to enjoy a (relatively) equal number of pension-years. These are examples for which there is clear empirical evidence for concluding that they threaten a society of equals; we do not claim that these are the only ones. Subsequently, in the light of the realistic expectation that some degree of socioeconomic health inequalities will persist, the outlook of relational equality provides us prospects of addressing unjust consequences. We show for each of the three examples of health-inequality related injustices how relational equality could be partly restored by changing social circumstances.

I. Evaluating socioeconomic health inequalities in the light of relational equality

As said, the debate on the fairness of socioeconomic health inequalities has primarily focused on a normative evaluation of their causes. Yet, regarding health more generally, other consequence-oriented arguments have been made that explain why health is of instrumental value for justice. Notably, Sridhar Venkatapuram (2011) argues in *Health Justice* that apart from its intrinsic value, being healthy is crucial for a decent human life. And in *Just Health*, Norman Daniels (2008) argues that health is of special moral importance for fair equality of opportunity. Both accounts take health as being instrumental for what an individual – given a certain understanding of justice – should be able to do and be.

This chapter scrutinises the hypothesis that also *equality in health* is instrumental for justice, and that socioeconomic inequalities are unjust because they lead to relational injustices. We thereby test a specification of the more general thesis formulated by Martin O'Neill (2008). He suggests that 'it is a deep social fact' that the realisation of an egalitarian society, i.e. a society in which people can live together as equals, requires that inequalities in conditions (e.g. in health) are eliminated (O'Neill 2008, 128). We take this notion of a 'deep social fact' as a helpful step in the evaluation of socioeconomic inequalities in health. For if we endorse the idea that people should be able to live together as equals, we need to know how *deep* this social fact is when it comes to inequalities in health. That is, to what extent do inequalities in health threaten the ideal of a society of equals, and if so, how? To answer this question, first more should be said about how to understand this ideal of a society of equals.

As O'Neill (2008) points out, ever since Rousseau, arguments to reduce inequalities have been motivated by several egalitarian values such as equal status, non-domination, self-respect and the absence of discrimination. By understanding equal distribution patterns of instrumental (or in O'Neill's words, 'non-intrinsic') value, rather than as an end in itself, O'Neill joins a family of views that goes under the header of 'relational egalitarianism' (e.g. Anderson 2010; Kelleher 2016; Schemmel 2011; Voigt & Wester 2015). For relational egalitarians, the general guiding idea is that 'in an egalitarian society people should relate to one another as equals or should enjoy the same fundamental status' (Arneson 2013, §4). For this reason, relational egalitarians argue that society's institutions should be 'designed to foster and reflect such attitudes' (Miller 2017, §6.3). When we speak in this chapter of relational equality, we have in mind this rather broad egalitarian ideal of a society of equals.

Following Anderson (2010), we take the demand of 'interpersonal justification' as central to relational egalitarianism. According to this view, principles of justice must be justifiable to others with whom we stand in morally relevant relations. Since inequalities should accord with the principles of justice endorsed, inequalities are unjust if they cannot be interpersonally justified. This generally forbids that an inequality 'reflects, embodies, or causes inequality of authority, status, or standing' (Anderson 2010, 2). Thus conceived, relational egalitarians take it that any inequalities in social standing that are caused by systematic inequalities in health cannot be justified and should thus be addressed.[1] While we will not argue for this here, we assume that the rationale of interpersonal justification is central to most of the relational egalitarian approaches that are recently distinguished in the literature (e.g. Kelleher 2016; Voigt & Wester 2015), in so far each of these relational strands take justice as 'a disposition [of agents, including institutions] to treat individuals in accordance with principles that express, embody and sustain relations of social equality' (Anderson 2010, 2). As we will argue, the perspective of relational equality reveals courses of action to mitigate unjust effects of *persistent* socioeconomic health inequalities.

But before we can start to think about mitigating injustices, we need to know if and how health inequalities threaten relational equality – or positively, to test whether it is a deep social fact that equality in health fosters relational equality. For this purpose, a broad and abstract ideal won't do. And so, to know what possibly indicates the absence of relational equality, we do make use of specific relational egalitarian arguments that have been formulated by others.

Since we rely on Anderson's account of relational equality, it makes sense to start with what she thinks is required by relational justice. In her well-known paper 'What's the point of Equality?', Anderson endorses the capabilities approach, and argues:

‘negatively, people are entitled to whatever capabilities are necessary to enable them to avoid or escape entanglement in oppressive relationships. Positively, they are entitled to the capabilities necessary for functioning as an equal citizen in a democratic state.’ (Anderson 1999, 316).

According to Anderson, functioning as an equal citizen involves functioning as a human being, as a political agent, and as an equal in civic society more broadly conceived, such as in the system of cooperative production. While the capabilities she lists are not extensively argued for, they give some guidance to see what is practically required to enable people to live as equals in society, and thus to indicate when health inequalities entail a risk – for the least healthy – of being deprived of the capabilities needed to function as equals.

For a more specific account of oppressive relationships, we use – like Anderson – Young’s (1990) characterisation of ‘five faces’ of oppression (i.e. powerlessness, marginalisation, violence, exploitation and cultural imperialism) in the context of 20th century welfare states. Regarding the examples we discuss, we show that unequal vulnerability to oppression lurks as a direct consequence of systematic health inequalities, and as such impede people to ‘develop and exercise one’s capacities and express one’s experiences’ (Young 1990, 37). Each of the three examples we discuss can in principle be analysed with Anderson’s capabilities and Young’s notions of oppression, as they indicate the implications of health inequalities for the quality of social relations, and the kind of opportunities individuals have. However, their accounts do not satisfactorily deal with the implications of health inequalities for other unequal distributions. We therefore rely on Schemmel’s argument, who explains a concern for distributions as a concern for the social bases of self-respect. According to him, as self-respect enables people to conceive of themselves as ‘free and effective agents’ (Schemmel 2011, 366), relational egalitarians should ‘seek to equalize the social bases of self-respect for all members of society’ (Schemmel 2011, 367). This is consistent with the demand of interpersonal justification, for without this sense of self-worth, people cannot be expected to consider themselves as worthy of making claims to others, ‘on an understanding of themselves as free, equal and mutually accountable persons’ (Anderson 2010, 3). As such, the distribution of the burdens and benefits of social cooperation constitute part of the social bases of self-respect.

Lastly, we should note that when we consider the effects of systematic health inequalities, we talk about inequalities *between groups*, which means that we cannot but speak in terms of risks and chances at a group level. Crucial for our analysis is therefore that we assume that we cannot speak of relational equality, if people – by belonging to some statistical *group* – are systematically *at risk of* being oppressed and/or of not being respected as equals. Of course, *actual* disrespect and oppression of individuals is the primary concern for relational equality. Yet unequal vulnerability to oppression and disrespect also implies unequal opportunity to live on equal standing. We hold that the unequal chance to live on equal standing – as caused by socioeconomic health inequalities – is a concern of relational justice as well. This can be illustrated by exploring how systematic health inequalities result in unequal risks of stigmatisation, unemployment, and enjoyment of pensions.

Health-related stigmatisation

Many health problems come with stigmatisation, hence inequalities in healthy life expectancy will imply inequalities in the risk of being stigmatised. Goffman originally characterised the stigmatised person as being:

> *'the stranger (…) possessing an attribute that makes him different from others (…) and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one.'* (Goffman 1963, 12)

In addition to *thinking* or *viewing* a person as inferior, Link & Phelan (2001) point out that it is crucial that when we stigmatise, we also *treat* the person as inferior. They thus propose a sophistication of Goffman's account, arguing that 'people are stigmatised when the fact that they are labelled, set apart, and linked to undesirable characteristics leads them to experience status loss and discrimination' (Link & Phelan 2001, 371).

Typical stigmatised health conditions that are known for evoking stereotyping and setting the affected persons apart are mental illnesses, leprosy, physical impairments, epilepsy, HIV/AIDS, tuberculosis and infectious diseases (Van Brakel 2006). Nowadays more attention is also given to stigmatisation of chronic conditions which are particularly common among lower socioeconomic groups, such as COPD, obesity and type 2 diabetes (e.g. Engebretson 2013; Puhl & Heuer 2009). These conditions are strongly related to behaviours, such as unhealthy eating or smoking that are known to be more common in lower socioeconomic strata. And so, stigmatisation of these conditions is primarily described as a matter of associations with 'irresponsible' or 'risky' behaviour. For instance, Whittle et al. (2017) describe how in San Francisco, persons living with HIV and/or type 2 diabetes mellitus and having a low-income, experience stigmatisation that 'centers on the perception that it is self-inflicted through poor-lifestyle choices' (Whittle et al. 2017, 10). Similarly, Dellaa et al. (2016) found that in Appalachian Kentucky, within economically disadvantaged groups, both persons being diagnosed with type 2 diabetes mellitus, and persons having obesity perceived stigmatisation and could count on moralising judgments, such as accusations of being 'lazy, irresponsible, and overindulgent'. Also, Berger et al. (2011) found that patients suffering COPD – often 'self-imposed' by smoking – experience stigma as they are blamed by healthcare providers, and internalised stigma in the form of self-blame.

Such 'blame-based' stigmatisation of health problems could be explained by neoliberal rationality. In the context of public health, neoliberal discourses are understood as shifting 'the onus of responsibility from the state to the individual' (Carey et al. 2017, 756), and as causing a so-called 'life style drift': the tendency in health policies to shift the focus from on the social determinants of health to individual behaviour. Lifestyle drift often comes with a move from policies aimed at the population as a whole, to targeting only the most vulnerable groups (Carey et al. 2017), such that especially lower socioeconomic groups are blamed for their health problems. A consequence of this is that those who fail to live as responsible healthy citizens, may expect 'public disdain and reproach for being a part of societal problems' (Ayo 2012, 104).

Moreover, the blame-based stigmatisation of illness related to behaviours that prevail under lower socioeconomic groups can be explained further if we acknowledge that stigmatisation presupposes unequal power relations. That is, to set others effectively apart as inferior requires social, economic, political and/or cultural power. Link & Phelan (2001, 376) illustrate this by discussing possible attitudes of mentally ill patients to their physicians and clinical staff: patients may distinguish certain staff members from others, by labelling the ones they don't like ('pill pushers'), stereotype them as arrogant and cold, ridicule them, and treat them differently by being uncooperative. Despite that all components of stigmatisation are in place the patients do not have the power to let the ridiculed physicians end up as a stigmatised group. To see whether stigmatisation can occur, crucial questions are:

> *'Do the people who might stigmatize have the power to ensure that the human difference they recognize and label is broadly identified in the culture? Do the people who might confer stigma have the power to ensure that the culture recognizes and deeply accepts the stereotypes they connect to the labelled differences? Do the people who might stigmatize have the power to separate "us" from "them" and to have the designation stick? And do those who might confer stigma control access to major life domains like educational institutions, jobs, housing, and health care in order to put really consequential teeth into the distinctions they draw?'* (Link & Phelan 2001, 376)

It is likely that these questions can be answered positively regarding higher socioeconomic groups, as higher educated groups generally occupy positions like those of healthcare professionals, healthcare insurers, and policymakers. As such, lower educated people are generally subjected to what those in more powerful positions judge to be blameworthy health conditions.[2] Carey et al. (2017) thus provokingly suggest that if obesity would have primarily affected high income groups, it would likely be framed more easily as a social problem requiring government responsibility.

So, socioeconomic inequalities in health imply an unequal risk of being stigmatised via stigmatised health problems. Of specific relevance for the health deprivations of lower socioeconomic groups is that – given that they are strongly related to unhealthy behaviours and given that neoliberal discourses dominate – these groups are at risk of 'blame-based' health stigmatisation. This risk is particularly high because the power to decide which behaviour-related conditions are blameworthy is generally at the side of the socioeconomically better-off.

Stigmatisation immediately harms relational equality. If we consider for instance the capability 'to be accepted by others, such as the ability to appear in public without shame, and not being ascribed outcast status' (Anderson 1999, 318), we can see that stigmatisation severely diminishes this capability. As Schemmel (2011) explains, stigmatisation ruins the social bases of a person's self-respect. An important social mechanism in this regard is the existence of social status norms, of which stigmas are typical instances. Such norms can be acted upon – thereby (unintentionally) treating others as inferior to ourselves. And they can be internalised – leading to feelings of shame, and eventually to withdrawal from social or public life, i.e. to marginalisation (cf. Young 1990, see next paragraph). Knowing that the condition you have is stigmatised by the society or community you live in, may lead to 'anticipated' stigma: the belief that one will likely be discriminated or otherwise negatively treated (Quinn & Earnshaw 2011). Both experienced and anticipated stigmatisation can be understood as instances of Young's fifth face of oppression: violence. By being violated Young means that either you are actually violated, or that you live in the fear of being violated. And this need not be physical violence, but may also involve 'harassment, intimidation or ridicule' (Young 1990, 61).

We can thus see that in a society with socioeconomic inequalities in health, *in combination with* prevailing health-related stigmas, power differences between socioeconomic groups, and neoliberal norms of individual responsibility, lower socioeconomic groups have a substantial higher risk of being stigmatised, and thus of being oppressed and of losing one's self-respect via health-related stigmatisation. Of such a society, we cannot speak of as a society of equals.

Health-related unemployment

On a more practical level, inequalities in healthy life expectancy are an immediate threat to people's standing as equals in the system of labour. For whether physically impaired, chronically ill or suffering mental health problems, all these conditions have been shown to have a negative effect on a person's ability to work. Barnes (2000) notes for instance that 'people with accredited impairments are substantially more likely to be unemployed and/or underemployed than contemporaries without perceived impairments' (Barnes 2000, 445). Denton et al. (2013) confirm this, finding that 'involuntary retirement' from the labour force was 8 times higher among Canadians with a disability than for those without. Minton et al. (2012) show that economic inactivity and unemployment is much higher among people with chronic or long-term illness, than among those without. Similarly, Schuring et al. (2007) found that in 9 of 11 European countries, perceived poor health was a risk factor for those being unemployed to stay unemployed and that in 7 of the 11 countries, perceived poor health was a risk factor for becoming unemployed. Regarding mental illness, the OECD mentions that employment rates are 10-15 % lower for those with common mental disorders than for those without, and for severe mental disorders, employment rate is even 25-35% lower. Moreover, the chances to unemployment are higher: 2-3 times for those with a common mental disorder, and 6-7 times for those with a severe mental disorder (OECD 2012).

Studies like these do not only show that health problems diminish an *individual's* chances on employment status, but also that the system of labour is competitive, and generally organised in ways that advantage those who are presumed to be most productive, i.e. the mentally healthy and able-bodied. It thus appears that in the system of labour, health is a 'positional good', for which it matters how it is distributed, and so it is that *equality in health* matters (cf. Axelsen & Nielsen 2015).

As with health-related stigmatisation, it appears that the risk of health-related unemployment is especially great for lower socioeconomic groups (e.g. Denton et al. 2011; Schuring et al. 2007). This is understandable, as 'higher socioeconomic status' is not simply a matter of education and income level but embodies several advantages that help to stay employed or find work again after long term illness, such as ‘resources of money, knowledge, power, prestige, and beneficial social connections’ (Hatzenbuehler et al. 2013, 814). Also, it seems easier for higher educated professionals – when faced with illness – to switch to less demanding (knowledge) work, than it is for non-professional or manual workers to switch to less demanding work in case of health problems. Moreover, employees in lower paid jobs generally have low degrees of job autonomy (e.g. Eurofound 2003), due to which employees have fewer opportunities to (re-)organise their work such that their being ill does not immediately render them ‘useless’.

For relational equality, the problem is that being involuntarily unemployed implies being excluded from the system of labour, and thus being deprived from a capability such as ‘occupational choice’ (Anderson 1999, 318). In addition to that, being unemployed makes one dependent on welfare benefits. In this regard, Young’s diagnosis of marginalisation as a common form of oppression within welfare states is – almost thirty years and an economic crisis later – still highly relevant. Young defines marginalised persons as those ‘the system of labor cannot or will not use’ (Young 1990, 53), and argues that they, by being dependent of welfare benefits, risk losing their status as an equal:

> *‘Today the exclusion of dependent persons from equal citizenship rights is only barely hidden beneath the surface. Because they depend on bureaucratic institutions for support or services, the old, the poor, and the mentally and physically disabled are subject to patronizing, punitive, demeaning and arbitrary treatment by the policies and people associated with welfare bureaucracies.’ Being a dependent in our society implies being a legitimate subject to the often arbitrary and invasive authority of social service providers and other public and private administrators who enforce rules with which the marginal must comply.’* (Young 1990, 54)

That this is an actual issue today, is shown by e.g. the study by Whittle et al. (2017) that reports how persons without jobs or with low income jobs are treated in humiliating ways when applying for welfare benefits.

And so, in a society with socioeconomic inequalities in health, *in combination with* a competitive system of labour that is (primarily) focused on productivity and where lower paid jobs come with lower job autonomy, lower socioeconomic groups have a substantially higher risk of unemployment, and thus of losing one's position as an equal in the system of labour. This is at odds with the ideal of a society of equals, as the higher risk of getting unemployed for lower socioeconomic groups indicates unequal opportunities for different socioeconomic groups to keep their equal standing.

Unequal pension enjoyments

A last salient inequality resulting from socioeconomic inequalities in life expectancy, is the fact that lower socioeconomic groups risk enjoying fewer pension years than higher socioeconomic groups. For instance, in the Netherlands, at the age of 65 persons with only primary education have a remaining life expectancy of 18,5 years, whereas persons with an academic degree may expect to live another 22,1 years (CBS 2016). This gap in life expectancy implies that those in the lowest socioeconomic positions are likely to enjoy substantially fewer years living in retirement than those in the highest socioeconomic positions, if the age of receiving a pension is based on the average life expectancy of the population as whole.

The fact that socio-economic health inequalities result in unequal pension enjoyments can easily be perceived as unjust, and hence this may be a good illustration of an instrumental evaluation of health inequalities. However, compared to stigmatisation and unemployment, it may be less evident that unequal prospects on equal pension enjoyment are an issue for *relational* justice.[3] It may seem more intuitive to understand unequal pension enjoyments as a distributive injustice, especially if we consider pensions as a means to provide in your material needs after working life. For most relational egalitarians, it is indeed unclear that unequal pension enjoyments matter. The 'distribution' argument generally used by relational egalitarians is that inequalities in wealth and income should be avoided to avert relations of oppression (e.g. Anderson 1999; Scheffler 2003), and this does not apply to unequal pensions in terms of amounts of pension payments. That is, would we – for the sake of the argument – assume that everyone receives the same amount of pension per month, then those living longer receive in total more pensions than those with a shorter life. Yet it is unlikely that this material inequality would lead to unequal power relations, for the simple fact that being oppressed assumes being alive.

However, there seems to be a way to see it as a relational injustice if we focus on inequalities in *duration* of pension enjoyments. We should thereby consider the issue as an issue of equal standing in the system of labour, such that we can understand the opportunity to enjoy a state pension for a certain number of years as a specific realisation of the capability *'to receive (…) recognition by others of one's productive contributions'* (Anderson 1999, 319).[4] In a situation in which one group risks enjoying their pension for a substantially smaller number of years than another group, we should at least conclude that people's productive contributions are *not equally* recognised. Still, this does not necessarily imply a relational injustice. For instance, Anderson – who is primarily concerned with *sufficient* capability levels, i.c. receiving 'sufficient recognition' – will not be bothered by unequal retirement prospects. Schemmel's (2011) argument for equal distributions provides a way to see *unequal* prospects on equal pension enjoyments as problematic for relational justice. He argues that relational egalitarians should care about equal distributions of the goods produced by social cooperation, because 'range constraints' on these goods

> *'express equal standing: if the basic structure has to display egalitarian concern for the participants in the enterprise of social cooperation that it regulates (…) it has to aim at distributing advantages and disadvantages that are socially produced equally'* (Schemmel 2011, 371)

Following this line of argumentation, state pensions – and the number of years they can be enjoyed – can be taken as such jointly produced advantages, as citizens contribute their share for state pensions by income taxes. And so, in a situation of *systematic* socioeconomic inequalities in life expectancy *and in case* there is a one-size-fits-all pension scheme, the lowest educated, and manual workers or nonprofessional workers, i.e. the groups with an, on average, lower life expectancy, are not respected as equals.

Still, we may wonder if we can also speak of a relational injustice here if the causes of health disparities are *not* unjust from a relational perspective. For instance, it seems less plausible that diminished pension enjoyments due to diseases with clear natural causes are unjust. Although it remains to be seen whether relational egalitarians have good reasons to think socioeconomic health inequalities are unjust based on their causes, but this is certainly not inconceivable (cf. Voigt & Wester 2015; Kelleher 2016).

II. Socioeconomic health inequalities and clustered disadvantage

We have started with the question of whether there is indeed a 'deep social fact' that connects equality in health with relational equality. We have presented and discussed evidence for this thesis by focusing on three exemplary ways in which health inequalities entail unequal risks of losing equal standing. Specifically, inequalities in healthy life expectancy imply unequal risks of being stigmatised, implying the risk of being deprived of the capability to appear in public without shame, and of being violated; they further imply unequal risks of unemployment, implying the risk of being deprived of the capability to occupational choice, and of being marginalised; and lastly, inequalities in mere life expectancy imply unequal chances to equal pension enjoyments, implying – *arguably* – the risk of not receiving equal recognition for one's productive contributions by others and thus of not being respected as equals.

We have also indicated that especially *socioeconomic* health inequalities threaten relational equality as the *impact* of health problems appear to be fiercer for those positioned in lower socioeconomic strata than for those higher positioned. Considering the higher risk of experiencing health related stigmatisation, this seems primarily due to the inequalities in the power to stigmatise that come with the division of labour between different socioeconomic groups. Considering the higher risk of health-related unemployment, this can be understood in the light of the diagnosis made by for instance Wolff & De-Shalit (2007) of 'clustering disadvantage'. That is, disadvantages in personal, social, and material circumstances tend to converge, and some of them likely interact in corrosive ways (see also Marmot

& Wilkinson 1999; Powers & Faden 2006). The corrosiveness of disadvantages can be (partly) explained by what Wolff & De-Shalit call 'inverse cross-category risk', meaning that being disadvantaged in one respect may 'force' people to take risks in another, thereby ending up more disadvantaged. For instance, whereas being ill for a longer period of time, easily leads to unemployment, this risk is higher when one's income is low: someone with asthma and little to spent may invest in better housing insulation to make her respiration problems bearable, but this may come at the cost of not investing in training for physically less demanding work, needed to stay employed. It also works the other way around: some advantages may be 'fertile' (Wolff & De-Shalit 2007). Being in good health and being well-educated likely stir the advantage of having a satisfying and well-paid job.

All in all, for people in lower socioeconomic strata, the prospects of standing as an equal in society is – (partly) due to their diminished prospects of a long and healthy life – much worse than for higher socioeconomic groups. If a society of equals is aspired, socioeconomic health inequalities and their effects on the opportunities to equal standing deserve attention by policymakers.

III. Mitigating injustices of persisting inequalities in health

Equal pension enjoyment

We start with the last example discussed, as here we can see most concretely how relational equality can be achieved even if socioeconomic inequalities in health persist. If equal prospects on equal pension enjoyments can be taken as a means to recognise people's contributions to the system of cooperative production, and thereby express equal respect to each individual, and if socioeconomic inequalities in life expectancy are a relational injustice based on their causes, then relational equality could be restored by accounting for the persistence of these inequalities in the set-up of public pension schemes.

In the light of rising average life expectancies, the future of pension schemes is hotly debated in many welfare states. In this context, several proposals have been made to ensure fair pensions for groups with a lower life expectancy than average. In fact, as Wester & Wolff (2010) show, many European countries already provide the opportunity to withdraw from the workforce to those working in hazardous occupations, such as miners and workers in heavy industries. Also, in the Netherlands, socioeconomic health inequalities are taken into consideration in the debate on the future of public retirement schemes, whereby pension enjoyment in terms of life years is generally focused upon. For instance, the Dutch branch of KPMG (a consulting company) has proposed to make public pension age dependent on education level achieved at the age of 35, and the correlating life expectancy for that group. Taking as a basis national statistics of life expectancy related to education level, rather than type of occupation, they propose that everyone should have achieved the same percentage of his/her life expectancy at the moment the pension starts (KPMG, 2017). Moreover, the Netherlands Interdisciplinary Demographic Institute as well as the Dutch Health Council recently argued that the lower health levels of lower educated groups should be accounted for in reformations of Dutch public pension schemes (De Beer & Van der Gaag 2018; cf. Burdorf 2013; cf. Lammers & Kok 2017).

Regardless of whether one agrees with the suggestion that unequal prospects on equal pension enjoyments are a relational injustice, these proposals can be said to be in itself relational egalitarian. For while they emphasise a fair distribution of the burdens and benefits of the system of cooperative production, these proposals are relational egalitarian in the sense that they aim to recognise the groups with a lower life expectancy as equals in the formation of policies and social arrangements. Or, to use the words of Schemmel (2011, 367), these proposals ‘express equal standing’ and ‘display an egalitarian concern’ to all participants in the system of labour.

Reducing risks to health-related unemployment

In case unemployment and dependency on public benefits due to health problems is unavoidable, it is key that people are treated respectfully. As Wolff (1998) argues, a revaluation of an ‘egalitarian social ethos’ is due here, meaning that policy makers and legislators both consider fair distributions, *and* values such as respect for privacy and trust. Yet this egalitarian ethos is only helpful at the point that people are unemployed and apply for welfare benefits.

But perhaps more can be done to prevent health-related unemployment in the first place, to protect people's equal standing in the system of labour and prevent marginalization. Defenders of the social model of disability and the disability movement have emphasised that the risk of unemployment that comes with disability is not merely due to the individual's physical or mental impairments, but the result of the interaction between the individual's environment and the impairment. That is, the eventual unemployment is a misfit between the job – i.e. the required skills and the work environment – and the individual's physical or mental abilities (Beatty & Joffe 2006). Also cultural and environmental factors are seen as important causes of the marginalised position of persons with a disability. For instance, Barnes (2000, 445) argues that 'the pursuit and maximization of profit, waged labour and competition between individual workers' form the dominant values that have informed the meaning of work in western societies since the 18th century. According to Barnes, it is due to these values that people with physical or mental impairments are effectively disadvantaged in the system of labour.[6] He calls for an improvement of the position of disabled persons, by challenging and reformulating 'the meaning and organization of work' (Barnes 2000, 449).

While competition and productivity are key-characteristics of a free labour market, it is worthwhile considering how egalitarian values like participation on equal footing could have a more central role. In fact, as Barnes shows, steps have already been taken in this respect. So-called 'welfare-to-work' programmes help unemployed to find work, by training and/or by paying employers a fee, and some progress is made in making buildings and transport systems better accessible for more people.

In case of persisting health inequalities, the task is to continue these developments, and to do this by explicitly considering those who risk becoming chronically ill or impaired later in life. A motivating perspective in this regard is offered by Beatty & Joffe (2006). They summon employers to treat persons with a chronic illness as a 'unique diversity category' in the sense that those persons will all face issues in terms of 'privilege, power, inequality, and stigmatisation' (Beatty & Joffe 2006, 188). Chronic illnesses exist in various degrees, and symptoms – often pain and/or a lack of energy – are notably unpredictable and can vary from day to day. Medication obviously can play an important role in suppressing these symptoms, but if they could do so perfectly, there wouldn't be a risk of unemployment. We can thus imagine all kinds of practical adaptations that could be made: from adjustable furniture and controllable temperature at the workplace, to flexibilization of working hours and working at home, to a redistribution of responsibilities and tasks.

Considering inequalities in health between groups helps to see that it is more than an individual affair. Although successful prevention of health-related unemployment should ultimately take into account individual health needs and individual work tasks, conceiving it *merely* as individual issues ignores the significant role that employers could play. Apparently, employees with a chronic illness are reluctant to discuss their condition out of fear for discrimination, credibility, and/or reputation damage, and so they do not actually discuss with their employers what adjusted work conditions they need to keep their job (Beatty & Joffe 2006). Rather than waiting for employees to ask for adjustments, Beatty & Joffe (2006) argue that employers should proactively develop policies that demonstrate compassion, and willingness for flexibility in terms of tasks and work conditions. By making publicly clear what steps employees can take in case of enduring illness, an environment could be created in which people feel safe to discuss what they need to stay at work.

Now, many of the measures that Beatty & Joffe (2006) mention seem to be achievable for professional jobs where employers have relatively high levels of job autonomy. As we mentioned above, for 'non-professional workers' working hour flexibility is usually a matter of 'one-way flexibility' and that 'junior, relatively unskilled, and peripheral workers are least able to control their working arrangements' (Peper et al. 2005, 5). And so, addressing health-related unemployment by adjusting working conditions, requires most efforts for lower paid jobs that demand less educational degrees.

Reducing risks to health-related stigmatisation

Although health-related stigmatisation is a universal and cross-cultural phenomenon, the values that stir it, and the degrees of stigmatisation differ. Alonso et al. (2009) report for instance a strong relation between mental disorders and stigmatisation in all European countries but find differences in degrees of stigmatisation between countries. This suggests that stigmatisation is persistent yet *could* be reduced in so far social and cultural norms are changeable. With regard to particular stigmatised diseases, several strategies have proven to be effective. Formally, stigmatisation can be addressed by legislation. Ratifications of the UN Convention of Rights of Persons with Disabilities, and laws like the Equality Act 2010 (UK) and the Mental Health Parity Act (US), do not only protect persons against discrimination, they also communicate that people with mental or physical impairments should not be discriminated. Less formally, public campaigns can help reducing stigmatisation by showing that stigmatising *is* a matter of injustice, and by informing what stigmatised health conditions entail. Also, making people familiar with stigmatised conditions by interpersonal contact, has been proven to be an effective means against stigmatisation (Cummings et al. 2013).

Regarding the combined stigmatisation of socioeconomic position and health instigated by neoliberal discourses, the task for public health policies seems to be to refrain from merely emphasising individual responsibility for health and aim to avoid the above mentioned ‘lifestyle drift’. Carey et al. (2017) suggest therefore to frame obesity as a problem of society as whole, not as a problem of specific groups, to make it easier accepted that obesity should be addressed by governments, rather than by individuals. This could help to prevent the stigmatisation that lower socioeconomic groups appear to experience when the phenomenon of socioeconomic health inequalities is covered in the media (Smith & Anderson 2017).

Since those who are disadvantaged in terms of socioeconomic conditions, have overall less control over the factors that influence their health, lower socioeconomic groups risk to be unjustly blamed for ending-up unhealthy. Those in the position to influence which health conditions are considered blameworthy (e.g. the higher educated healthcare professionals, medical teachers, policymakers, etc.) are also in the position to counteract the health-related stigmatisation of those in lower socioeconomic strata. Ultimately, their concern should be to treat people as equals, despite of their health problems.

Conclusion

We have argued for an instrumental evaluative approach that assesses to what extent socioeconomic inequalities in health threaten relational equality. Instrumental evaluation – which takes equality in health not of intrinsic, but of instrumental value – is understood as complementary to evaluations of the causes of health inequalities. We have shown how inequalities in (healthy) life expectancy threaten relational equality in at least three ways: via the risk of fewer years of pension enjoyment, via the risk of health-related stigmatisation, and via the risk of health-related unemployment. We have described these effects of health inequalities as relational injustices by indicating how the least healthy are at risk of being oppressed, notably by violence and marginalisation, and of not being respected as an equal in the system of labour. Since disadvantages cluster, the risks of these injustices are especially great for those in lower socioeconomic strata.

In addition, we have argued that these threats to relational equality, are not simply due to inequalities in health, but also to the ways in which contemporary welfare states are generally structured and organised. Acknowledging this, opens a way to mitigate these injustices by adjusting social circumstances, rather than people's health, e.g. by adjusting pension schemes, addressing health related stigmatisation and adjusting work conditions. Also regarding mitigating injustices, the most efforts are to be made in relation to those in the lower socioeconomic strata: when faced with health problems, the barriers to equal standing are greater for those with a lower level of education and/or income than for higher socioeconomic groups.

We conclude with two possible objections. Firstly, some readers will hear the echo of the social model of disability in these proposals to focus on circumstances, rather than on health conditions. And, just like the social model of disability may have gone too far in blaming society rather than health conditions (Shakespeare 2012), the worry here may be that our approach provides a license to stop investments in public health and medical treatment, or to stop worrying about the social determinants of health. We have indeed argued that flexible public pension schemes should be considered, that society wide efforts are to be made to address health-related stigmatisation, and that there is an agenda for both employers and employees to explore what efforts can be made to protect employment among those with health problems, and that the need to make these efforts is especially high for those lower down the socioeconomic scale. However, we have done so in the expectation that some degree of socioeconomic inequalities in health will persist, *and* in the assumption that simultaneously efforts are made to bring people's health to the best attainable level. That is, if health problems are caused by the absence of proper nutrition, hygiene, health care, medication, etc. it would be wrong and pointless to only take refuge to changing people's circumstances for the sake of their equal standing. The here defended instrumental approach should thus by no means be taken as a permit to stop investments in healthcare or public health measures.

Secondly, one may object that our analysis pictures the problems of socioeconomic health inequalities in a too linear way. We have indeed conceptually discerned the causes and social determinants of health inequalities from their consequences, to distinguish different types of normative arguments and different directions of mitigating injustices. But as empirical studies and the clustering of disadvantage show: addressing causes and addressing consequences will in practice strengthen each other. That is, the here discussed proposals to restore relational equality will likely improve health itself, given what we know about the negative health effects of stigmatisation (cf. Hatzenbuehler et al. 2013), unemployment (cf. Schuring et al. 2007), working in hazardous conditions (cf. Wester & Wolff 2010). Indeed, in Norman Daniels's words, 'justice is good for our health'!

Notes

1. We thus reject the luck egalitarian objection that inequalities in equal standing caused by health inequalities that stem from free choices would be

justifiable. Not only because it is unlikely that systematic inequalities in health stem from truly free choices, but also because we concur with Anderson that the implications of this view are too harsh (Anderson 1999; 2010).

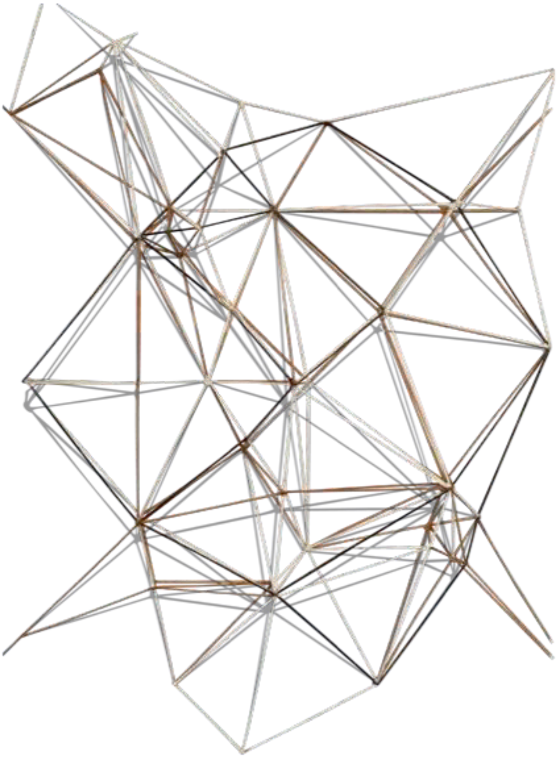
2. One could object that pensions were never meant to serve this function, as pension age was originally set at ages that people would be expected to die, and thus only serve the needs in the very latest days of people's life. But this would ignore the change of meaning that pension schemes have undergone, and that it functions nowadays much more as a social right.

3. Examples of such 'blame-based' stigmatisation are conditional clauses – e.g. losing weight, quit smoking – for medical treatment and health insurance (Campbell 2017; Schmidt 2008).

4. Note that instead of relational equality, other normative outlooks for instrumental evaluation are conceivable, such as wellbeing. We leave it an open question to what extent diminished wellbeing due to ill-health can be restored without restoring health, as this would depend on how wellbeing is understood.

5. Barnes thereby echoes Young's definition of exploitation as a modern form of oppression in the sphere of labour: 'Exploitation enacts a structural relation between social groups. Social rules about what work is, who does what for whom, how work is compensated, and the social process by which the results of work are appropriated operate to enact relations of power and inequality' (Young 1990, 49-50).

PART III:
Synthesis



Chapter 8

Discussion

Chapter 8 Discussion

If the fact that Anna has much more favourable health prospects than Mark makes us feel uncomfortable, we can now say a bit more about why there are likely good reasons for this moral discomfort. For the intuition that this difference is unjust can be explained if there are social structural processes that disadvantage Mark in several ways, while benefitting Anna. Both Mark and Anna play a role in upholding those social structural processes. Yet, as individuals, Anna cannot be blamed for this, and Mark cannot make any claims to Anna regarding his lower healthy life expectancy: it is a whole complex of social mechanisms that lead to health inequalities between socioeconomic groups. Also, given the ways in which society is organised and social mechanisms, their unequal health prospects may lead to further injustices. To the extent that their unequal health prospects persist, society should aim to mitigate the unjust consequences that people like Mark are at risk of, and protect their opportunities to function as equals. Lastly, there appears to be no reason to focus more on their unequal prospects in objective health conditions, than in subjective, self-perceived health.

This dissertation started with the question: *which health inequalities deserve our focus if we are concerned with social justice?* This question was motivated by the expectation that not all concepts of health and not all health indicators might be equally relevant from the perspective of justice, and that more focus is desirable for health equity policies.

The strategy to address this question involved studying concepts of health in the hope that this could offer partial guidance for subsequent justice evaluations. One could be sceptical about this approach, as the comparison of theoretical health concepts did not result in a single concept that should guide health equity policies. Instead, these conceptual studies showed that we have no reason to focus more on some health inequalities than on others. For someone expecting our study would make the basis for health equity policies and research simpler may find these outcomes disappointing. However, findings such as that inequalities in subjective health *are* relevant for justice are interesting and important. Moreover, the studies into justice evaluations of health inequalities provide *some* keys to bring more focus in health equity policies. To see how they do so, I will conclude this chapter by discussing what these studies tell us further about the relevance of the different health indicators and by formulating recommendations for public health policy and research.

But first, it is good to summarise the most important findings and address some of the many questions that the foregoing chapters may have raised. In line with the two parts of the dissertation, I will do so for the chapters on health and justice separately.

I. Central findings and points of discussion regarding the meaning of health

In the first part, I have argued that how we should conceptualise health may differ per practice and context, because different practices may be guided by different values, and also because 'health' has both a descriptive and an evaluative dimension. *Because* health is a partly evaluative term, views on health as endorsed by citizens are relevant to take into consideration too. The concept map study of these 'lay' views on health showed that health is understood as a multidimensional term, and that its understanding slightly differs per socioeconomic group. Our findings were in accordance with other studies to lay views on health. Considering these conclusions in the light of the justice-related concerns of impartiality, equal treatment, and recognition, I have shown that for practices concerned with health equity, we need not exclude indicators that focus on subjective and relative health aspects. However, we should thereby be aware of the tendency to mental adaptation to living conditions which by definition differ between socioeconomic groups.

More specifically, chapters 2, 3 and 4 showed that:

- A comparison of health concepts from the philosophical and public health literature reveals how different health concepts highlight health as a naturalistic or normative term, a reductionist or holistic term, a subjective or objective condition, an internal or circumstantial condition, a relative or universal standard, and as differentially understood in relation to disease and to wellbeing (chapter 2)

- An understanding of how health concepts differ may serve critical reflection on, and enhances an understanding of, the assumptions and purposes of health practices (chapter 2)
- Dutch citizens of different socioeconomic strata revealed a multidimensional understanding of health, and they ascribed most importance to mental health (chapter 3)
- Compared to higher socioeconomic groups, lower socioeconomic groups showed a conceptualisation of health that refers to the absence of health threats rather than to positive aspects, to a person within his/her circumstances more than to a quality of the body and mind, to the value of functional rather than hedonistic notions, and that reveals an accepting – i.e. resigning – more than an active attitude towards life (chapter 3)
- A concern with impartiality and equal treatment does not mean that we should ignore subjective health measures, as perceived health is an indispensable aspect of health. But subjective health measures should be accompanied by objective measures to ensure an impartial assessment of health inequalities (chapter 4)
- Preventing misrecognition of lower socioeconomic groups is a reason for policymakers to take into account the views of health prevailing among these groups (chapter 4)
- Since socioeconomic differences in views of health may be due to mental adaptation to socioeconomic position, policies should align with health aspects that are valued by different socioeconomic groups (chapter 4)

Chapters 2 and 3 are journal articles which in that form did not allow further elaboration on points that demand further discussion. Chapter 4 addressed some of these points by discussing the question of whether subjective health measures and relative health norms are problematic for the pursuit of health justice; and the question of how to think of the idea that views of health by different socioeconomic groups should be considered. But this chapter does not address the question of what is after all the relevance of a comparison of theoretical health concepts and the distinctions drawn, if not for determining focus in health equity policies. Moreover, both conceptual studies might have given rise to the question of whether we should endorse a new health concept or develop new indicators of health. For this reason I will here focus on the philosophical and practical merits of the conceptual studies and the eventual need of new health measures and concepts.

Philosophical merits of comparing theories of health

Our comparison of theoretical health concepts may not have helped in bringing focus in health equity policies, but it has arguably contributed to the philosophical debate about health. For the comparison of theoretical health concepts shows why concepts *per se* generally do not provide reasons to prefer one understanding of health over others. While internal consistency speaks in favour of a good theory, the arguments to prefer one concept over another more often depend on the context or practice in relation to which the concept is formulated.

That the adequacy of health concepts depends on contexts or practices seems inherent to the motivations behind theories of health, as we can see if we recall the practices in relation to which concepts of health have been formulated. That is, right after WWII, the WHO formulated its ambitious definition of health as ‘a state of complete mental, physical and social wellbeing’, and referred to health as being ‘basic to the happiness and harmonious relations and security of all peoples’. Health is thereby pictured as an ideal and a precondition for world peace. In contrast to this, in the 70’s, Boorse made a plea for a scientific theory of health as absence of disease. This was a response to the anti-psychiatry movement, that raised the question if and how we could distinguish socially deviant behaviour from mental illness. Boorse aimed to show that we *can* distinguish the two by formulating a value free definition of disease that coheres with medical sciences. In direct response to Boorse, Nordenfelt formulated a theory of health that would better fit our ordinary use of the term, in which health is seen as something valuable for the wellbeing and agency of individual persons. Venkatapuram in his turn twisted Nordenfelt's theory such that that it could serve the aspiration for global health justice, that in his view demands more attention is paid to the social determinants of health as well as for universal standards. In the developed world context of aging of populations and medical progress, due to which living with chronic disease has become relatively normal, Huber et al. formulated a concept of health in terms of adaptation and self-management.

Different theories are thus formulated in relation to and aspire to be adequate for different contexts and practices. Considering this, I have explicated what seems (generally) implicitly assumed in debates about health concepts: that the adequacy or aptness of a health concept (partly) *depends* on what practice or context the concept aims to guide.

This pragmatism regarding how we should think about and discuss health concepts is also advocated by Tengland (e.g. 2007). He argues that a health concept ideally tells us

> *'how we should use the term given our practical and theoretical purposes in fields and professions like medicine, health care, rehabilitation, social work, psychotherapy, health promotion, and public health.'* (Tengland 2007, 259)

In agreement with this statement, I added to this that because of the diversity of these practices there may not be *one* health concept that can guide all health promoting practices. This does not preclude that health practices may in the end be less diverse than I assumed them to be, so that we can ultimately do with one single overarching health concept for all health promoting practices. But this is something we can *only* find out by considering the diversity of practices when developing, formulating and refining health concepts.[1]

Practical merits of comparing theories of health

The idea that the adequacy of health concepts at least partly depends on the practice they aim to guide thus allows for the coexistence of several health concepts. Not only is this the result of the diversity of health promoting practices, but I also proposed to see this as a practical merit of studying different health concepts. Alternative views may serve critical reflection and eventual reorientation of existing health promoting practices if the latter are deemed problematic. I thereby argued that the distinctions revealed by a comparison of different concepts – i.e. naturalistic/normative, reductionist/holistic, subjective/objective, internal/circumstantial, wellbeing and disease – may help to structure such reflection.

However, perhaps it is more appropriate to say that more than *structuring* critical reflection and reorientation, the conceptual distinctions drawn in chapter 2 can help us *understand* fundamental points of dispute in discussions about the purposes and focus of health promoting practices. The debate in the Netherlands about Huber et al.'s concept of health is illustrative in this regard, as this also entails a debate about the purposes of health promoting practices. In this debate, the distinctions that we drew in chapter 2 are not used literally, but the questions underlying these distinctions are central. For instance, the very initiation of Huber et al.'s concept can be explained as a proposal to shift from a reductionist to a holistic view on health in health promoting practices (Huber et al. 2011). In response to this proposed shift, critical voices question how Huber et al.'s concept pictures health in relation to wellbeing and disease. That is, doesn't it downplay the relevance of disease for people's lives and with this the centrality of disease for health professionals? And is the concept's concern with spirituality and emotional wellbeing an appropriate focus for health care providers? (e.g. Buijs 2017; Poiesz 2015). These questions suggest that the relevance of a reductionist view on health for some health care practices is insufficiently acknowledged. At the same time, while Huber et al.'s concept is holistic, the centrality of self-management seems to conceptualise persons as independent and autonomous actors. Therefore, Jambroes et al. (2015) further address the question of whether this concept of health does not tend to ignore the social determinants of health, such as the socioeconomic *circumstances* of the individual.

And so, an understanding of the various ways in which concepts of health differ can enhance our understanding of the central points of dispute regarding practices of health promotion.

A need for new health measures?

Formulating a new theory of health to serve health equity policies has not been the aim of this project. Rather, the concern was to find out whether commonly used health measures are all equally relevant for health justice. The aim of comparing different – existing – concepts of health was to better understand the normative assumptions of different health measures. Surprisingly, the result of these conceptual studies is that we have no good reasons to focus more on some health measures than on others.

Nevertheless, these conceptual studies could be taken as indicating reasons to endorse a *new* health concept or to expand the scale of health measures for health equity policies. For instance, Venkatapuram's account as elaborated in *Health Justice* could be understood as providing the answer to the very question this dissertation started with. His theory of health is formulated in support of social justice and states that those health deprivations should be focused upon that hinder people to achieve Nussbaum's ten central human capabilities needed for a decent human life. This is a direction of thought that needs further exploration to see its fruitfulness. Practically, adopting Venkatapuram's concept of health would require radical changes in the way we currently measure health inequalities. While Venkatapuram considers physical and mental conditions to be important constituents of health (e.g. Venkatapuram 2016), measuring health as a meta-capability would require much more. For if health is a meta-capability to achieve the ten central human capabilities as listed by Nussbaum, measuring health would entail measuring social and material circumstances and arguably societal background conditions (cf. Richardson 2016). Theoretically, Venkatapuram's account comes with the question of what exactly the central human capabilities require. Considering Nussbaum's suggestion that the central human capabilities should be specified in relation to a given society, a further development of this approach would entail for instance an empirical investigation into prevailing values and norms in a particular society.[2]

Also, the concept map study, together with my discussion of the recognition as a concern of justice, may be taken as providing reason to expand the scale of health indicators, since people of all socioeconomic strata appear to understand health in a multidimensional way and assign most weight to mental health. However, because there is already a plethora of health indicators used – more than I have discussed – the fact that health is understood in a multidimensional way by all groups rather tells us that there is no reason to change this practice.[3] The fact that all socioeconomic groups assigned most weight to mental health supports the idea that more attention should be given to (inequalities in) mental health, which is also proposed by the WRR (Broeders et al. 2018).

II. Central findings and points of discussion for justice evaluations

The second part started by considering direct evaluation of inequalities in (healthy) life expectancy from a sufficientarian perspective. It appeared that the two sufficientarian approaches examined – i.e. a 'contextual' approach, and an 'external' approach – either confront us with the question of what we deem to be 'avoidable' health deficits, which demands a concern with the social determinants of health; or they confront us with the question of what we understand by minimal health levels, which is best answered by taking health as being of instrumental value for another ideal.

Regarding the first route, i.e. specifying the notion of avoidable health inequalities, an indirect evaluative approach with the help of Rawls's principles of justice appeared to be unsatisfactory. For Rawlsian principles cannot accommodate the complexity of the social determinants of health, and thus cannot adequately tell us what a just distribution of the social determinants of health would be. To evaluate socioeconomic health inequalities while considering the complex processes by which they arise, a broader understanding of the subject of justice is needed. This, I argued, becomes possible by understanding health inequalities as structural injustices as conceived of by Young.

For the second route, it appeared that sufficient health to function as an equal in society sometimes requires equality in health. To judge under what conditions this is the case, the effects of persistent health inequalities should be evaluated. As examples, we indicated the (probable) unjust effects of health inequalities on prospects on pension enjoyments, employment chances and risks to stigmatisation. Moreover, with this instrumental evaluative approach, we can point out ways to mitigate injustice alternative to the strategy of improving health itself. More specifically, chapters 5, 6 and 7 showed that:

- Sufficient health is an appropriate aspiration for justice but defining non-arbitrary health threshold levels is difficult if not impossible (chapter 5)
- The literature on sufficient health reveals at least two routes to determine what justice demands in terms of health: by considering what health level is feasible in a given society (the 'contextual approach'); and by deriving a health minimum from an external ideal (the 'external approach') (chapter 5)
- Both routes lead us away from direct evaluation: the first route leads to the question of how to evaluate the causes of health inequalities; the second route to the question of whether specific consequences of health inequalities are unjust (chapter 5)
- While Daniels's account initially seems to provide a way to normatively demarcate the category of avoidable health inequalities, it cannot deal with the full complexity of the social determinants of health because of Rawls's understanding of society's basic structure (chapter 6)
- To adequately capture the complexity of the social determinants of health, we should broaden our understanding of society's structure, as is proposed by Young (chapter 6)
- Understanding socioeconomic health inequalities as structural injustices in Young's sense implies pursuing non-ideal theory, and blurs the distinction between direct and indirect evaluation (chapter 6)
- Considering the consequences of persistent health inequalities in light of relational equality shows that equality in health can be of instrumental value (chapter 7)

- Examples of such unjust consequences include the higher chances on fewer years of pension enjoyment, unemployment and stigmatisation of lower socioeconomic groups (chapter 7)
- The instrumental approach shows that unjust consequences of health inequalities can also be mitigated by changing social circumstances, rather than reducing health inequalities themselves (chapter 7)
- Both in addressing the health inequalities themselves and in mitigating their consequences, priority should be given to groups where disadvantages cluster as it is likely that health problems have the most severe effects in these groups (chapter 7)

Although chapter 5 explicates the link between chapter 6 and 7 – both of which were written as separate journal articles – there are several theoretical issues that may have remained unclear or unexposed. This is particularly the case for my changing positions regarding distribution patterns, what I think of direct and indirect evaluation, my understanding of (the relevance of) ideal and non-ideal theory, and my understanding of the ideal of relational equality. Therefore, these topics will have the focus in what follows.

Sufficiency, equality and priority?

My take on distributive rules – i.e. on what the right pattern of distribution is – as put forth in this dissertation may strike the reader as confusing. For while chapter 5 takes sufficientarianism – the requirement that everyone is healthy enough – as an appealing moral outlook, chapter 6 and 7 may rather read like a plea for egalitarianism – everyone must have equal health – while chapter 7 also suggests prioritarianims – that priority should be given to the least healthy. This requires clarification. Because I have not provided any 'knock-down' arguments for either equality, sufficiency or priority views, I will use this paragraph to briefly explain how I think the three distributive views can actually complement each other – at least in so far we are concerned with health justice.

In support of a sufficiency view, I have followed Anderson in her argument that what matters for justice is that everyone has *sufficient* capabilities to live on equal standing as persons in public life, as workers in the system of labour, and as citizens in a political state. In other words, to have sufficient capability levels to live on equal standing is what we owe to each other, and so, we have – what Parfit (1991) calls – *deontological* reasons to aspire to sufficiency as the pattern of distribution.

But it is not clear what counts as sufficient health in the light sufficient levels of capabilities. For whether a person's health level suffices to function as an equal depends on various social and material circumstances. Considering these contextual circumstances, sufficient capability levels to live on equal standing sometimes practically require equal levels of some goods. In other words, having enough *could* demand having the same. As noted in chapter 5, this is especially the case with so-called positional goods (cf. Axelsen & Nielsen 2015). And, as demonstrated in chapter 7, sometimes health is a positional good. That is, to the extent that social and material circumstances are 'tailored' to what people are on average – mentally and physically – able to do, inequalities in mental and physical abilities matter. For instance, the job market is generally adjusted to 'able-bodied' and 'able-minded' workers, which disadvantage people with chronic mental or physical diseases. And so, depending on how societies, institutions and social arrangements are organised, inequalities in health may form an obstacle to relational equality. Therefore, we have *instrumental* reasons to aspire to *equality* in health (cf. O'Neill 2008).

Moreover, equal distribution patterns may not only be of instrumental value for justice but can also indicate justice. As argued in chapter 6, inequalities in levels of wellbeing and social status between groups, like socioeconomic health inequalities, can indicate a structural injustice, but they need not. They only do so if these inequalities are the result of oppressive social structural processes. Therefore, although *inequality* in health need *not* indicate a structural injustice, *equality* in health *does* indicate the absence of structural injustice in health.

The prioritarian-minded proposal in chapter 7 could be understood in the light of ideal/non-ideal theorizing. As I discuss further below, the distinction between ideal and non-ideal theory can be explained as the distinction between end state and transitional theory. The point of non-ideal theory in the sense of transitional theory, is to tell us how we get from an unjust situation to a just situation (cf. Robeyns 2008; Valentini 2012). That ideal theory cannot always tell us how to make the world more just, can also be seen if we consider different rule of distribution. That is, the ultimate aspiration to sufficient health, which in some circumstances demands equal health, could be taken as the *ideal* distribution pattern.

We can thus think of sufficient capability levels to live on equal standing in public life, in the system of labour, and in a political state, as the ideal situation. But in a *non-ideal* situation where money is scarce and where people are not always inclined to treat each other as equals, the sufficientarian ideal confronts us with a choice: should we focus on bringing the larger group that falls only a little short closer to the threshold, or should we focus on bringing the few that fall severely short closer to the threshold? In policymaking, where cost and efficiency considerations may drive towards what is known as 'threshold fetishism' (e.g. Wolff & De-Shalit 2007, 93). This means that the first option – bringing the larger group that falls only a little short to the threshold – will easily become the focus of policies, given that such policies are likely most efficient as well as cost-effective. However, this would ignore the smaller, worst-off groups. If we think that – from a justice perspective – those with the greatest needs should be helped first, prioritarianism offers the most just response to real world health deprivations.[4] Moreover, since equality in health is of instrumental value, giving priority to the worst-off is preferable in so far it contributes to decreasing the health gap between the very worst-off and the best-off.

Direct and indirect evaluation

My emphasis on the importance of non-ideal theory for evaluating socioeconomic health inequalities, challenges the distinction between direct and indirect evaluation. I have taken this direct/indirect distinction as a starting point for the chapters on justice evaluations, because it regards a key question of what should be the focus in evaluating of socioeconomic health inequalities: inequalities in health or inequalities in socioeconomic status? Put briefly, I found that these two kinds of inequality are too mixed up to make sense of the direct/indirect distinction when evaluating socioeconomic health inequalities in the real world.

As explained in the introduction and in chapter 5, direct evaluation takes the distribution of health as an independent moral concern, because being healthy is important in the light of social justice. And so, regardless of whether one thinks health is of intrinsic or of instrumental value, or both, direct evaluation is the preferable approach.

However, chapter 5 showed that direct evaluation confronts us with the question of the right distribution pattern for health. Concerned with health, most egalitarians (e.g. Whitehead 1990) and some sufficientarians (e.g. Powers & Faden 2006) refer to the avoidability of health inequalities or health deprivations to indicate their injustice. Most direct evaluative approaches thus demand that more must be said about what we consider to be 'avoidable' health inequalities or health deprivations. In case of socioeconomic health inequalities, this comes with the question of what we deem avoidable in terms of socioeconomic inequalities. And so, *unless* one thinks that health is the most important good such that any inequalities in income or education level are unjust as they result in health inequalities, the notion of avoidability leads us to indirect evaluation.

And, as pointed out in chapter 6, the distinction between direct and indirect evaluation becomes almost unintelligible if we look at the avoidability of the socioeconomic determinants of health from a non-ideal perspective. If we take into account the full complexity of the social determinants of health, and how disadvantages in health and in socioeconomic conditions interact and enforce each other, the distinction between direct and indirect evaluation dissolves. That is, by taking socioeconomic health inequalities as indicating structural injustice, this approach entails direct evaluation in the sense that it takes health to be important for justice, and thus takes inequalities in health as *a* moral concern. But the evaluation is indirect in so far it does not take health inequalities as an entirely 'independent' moral concern. For to count as a structural injustice, the question is whether we can explain health inequalities as the product of social structural processes, of which a poor socioeconomic position may be both cause and effect.

Another option for (sufficientarian) direct evaluation is to derive a health threshold from an external criterion that tells us what it is that we need to be sufficiently healthy for. This route of instrumental evaluation could be taken as leading to an additional form of indirect evaluation, in so far it derives a judgment about the justness of health inequalities from a judgement about the justness of their consequences. But here too, the distinction between direct and indirect evaluation is not *that* sharp. For considering the probable unjust consequences of health inequalities reveals that the effects of socioeconomic health inequalities likely enforce their persistence, such that consequences and causes are not as clearly distinguishable as the distinction between direct and indirect evaluation suggests.

And so, we may conclude that the direct/indirect distinction is an analytical distinction that may be helpful to get the moral basis of evaluation clear, but that is after all difficult to uphold in the face of real-world inequalities.

Ideal or non-ideal theory

In the above points of discussion, as well as in chapter 1 and in chapter 6, I have referred to the distinction between ideal and non-ideal theory, arguing that evaluating socioeconomic health inequalities demands non-ideal theory. But how precisely should we understand this distinction, and how is it relevant for this dissertation? Arguably, any work in applied ethics or applied philosophy that aspires to be relevant for practice is ‘non-ideal’ as it aims to offer guidance in how we deal with real world issues, such as socioeconomic inequalities in health. And so, my remarks can be taken as some meta-theoretical chatter that might just as well be ignored. Still, this meta-theoretical issue may help to understand some of the difficulties that come with the justice evaluations of socioeconomic health inequalities. And so, without explaining the whole debate about ideal and non-ideal theory, and all the different interpretations (cf. Valentini 2012), I will clarify my remarks a bit further here.

At first instance, for the evaluation of the justness of socioeconomic health inequalities we seem to need ideal theory. That is, it seems most natural or obvious to compare these inequalities with a perfectly just situation, or with a 'mythical paradise island', as Robeyns (2008) puts is, and examine if and to what extent these inequalities deviate from this ideal. But soon it will appear that these ideals are highly abstract, and that there are so many ways in which the real-world deviates from these ideals, that we should either conclude that the real world is simply not perfectly just, *or* that the ideal is too vague to tell us how to evaluate real-world inequalities. Take for instance the sufficientarian direct evaluation of socioeconomic inqualities in chapter 5. It appeared that Nussbaum's theory of a decent human life leaves the thresholds and precise content of the central human capabilities unspecified, such that both 'sufficient health' and a 'decent human live' remained abstract notions. And so, when considering *specific* inequalities, such as socioeconomic health inequalities in high income countries, it remains unclear how we should evaluate them.

Another example is the appeal to Rawls's principles of ideal justice as a basis for indirect evaluation in chapter 6. Even in Daniels's adjusted version, they fall short in telling us how to evaluate socioeconomic inequalities in health. Here, the abstraction of the ideal comes with the assumption of 'full compliance': Rawls's and Daniels's theories assume that people behave both in accordance with the principles of justice *and* in ways that are good for their health. In this sixth chapter, I primarily focused on the idealised understanding of society's basic structure that cannot capture the complex social structures that lead to health inequalities. This led me to Young's non-ideal theory, in the sense of 'partial compliance' theory: a theory that acknowledges that people may act unjust, and often act in ways that do *not* result into just and healthy outcomes.

It also appeared that if we drop the idealisation of society's basic structure, and think in terms of social structural processes, the distinction between direct and indirect evaluation disappears. The reason for this is that as soon as we consider how socioeconomic inequalities *actually* emerge and persist over generations, it becomes difficult to separate socioeconomic injustice from injustice in health. It is the whole complex of social structural processes that lead to and increase disadvantages in several respects (cf. Powers & Faden 2006; Wolff & De-Shalit 2007). Put differently, both direct and indirect evaluation demands that we 'idealise' inequalities and ignore the interactive processes between socioeconomic and health deprivations. This is fine for discussing a fundamental moral debate, but less fulfilling if one also wants to consider ways to address the injustice, or to make what Sen (2006; cf. Robeyns 2008) calls 'justice-enhancing changes'. For we cannot make the world more just based on an idealisation of the world. We need to consider how the world really is, in order to understand how injustices actually come about, and to estimate how well-intended actions and interventions will work out in practice.

Although I have started with the principal moral question of how to evaluate socioeconomic health inequalities, my focus has shifted to the more pragmatic question of how to approach the ideal of justice given the complexity of the real world. Before explicating the preliminary directions of thought for making justice enhancements provided with this dissertation, I will clarify some issues regarding the 'ideal' in relation to which these justice enhancements are developed: that of relational equality.

Relational equality

In the second part – especially in chapter 5 and 7 – I argued for a 'relational egalitarian' perspective on social justice. I have referred to this perspective as a family of views, each of which aspires to a society of equals, and each of which (implicitly) endorses the idea that principles of justice should be interpersonally justifiable. One may find this characterisation too vague, but an in-depth discussion of how exactly to understand relational egalitarianism, its roots, its limits, and its affiliations with for instance ethics of care, would go beyond the scope of this chapter. Instead, I will describe the work of both Young and Anderson as representing two slightly distinctive 'frames' by which relational egalitarianism can be explained, since my analyses on justice evaluations heavily relied on their work.

A first frame is to see concerns of relational equality as moving away from the increased focus on the fairness of distributions since Rawls's *Theory of Justice* (e.g. Voigt & Wester 2015). It is in this regard that we can best understand the work of Young in the relational egalitarian 'tradition'. Young's critique of the 'paradigm' of distributive justice directs our attention to the repressive effects of social structural processes (e.g. Young 1990, 2006). While she does not consider distribution patterns irrelevant for justice, Young points out that taking social justice primarily as a matter of distributive justice disregards the various forms of oppression and domination that *precede* unequal distributions. By taking oppression and domination as the central characteristics of social injustice, relations of equality – that is, relations that are neither oppressive nor dominating – become an indication of social justice.

Regarding socioeconomic inequalities in health, I have found Young's work particularly helpful to understand socioeconomic health inequalities in the context of industrialized and high-income societies. For these societies are marked by forms of (socioeconomic) oppression and domination, that are generally not so salient or obvious as they work via complex social structures. As such, these forms of oppression often have no clearly identifiable 'wrongdoers', but nevertheless make that lower socioeconomic groups often live in various disadvantaged conditions, such as in poor physical and mental health.

Although Young's work looks especially at social justice in the US, as well as at global justice, I have taken the oppressive mechanisms she describes as sufficiently generic to extend her analysis to e.g. European contexts. This might be too simplistic and in need of further examination. Doing so would in fact be encouraged by an engagement with Young´s work, given that Young herself gives due consideration to contextual factors and their influence on social relations.

A slightly different way to characterise relational egalitarianism is provided by Anderson (e.g. 2010a), who explains relational egalitarianism in opposition to luck egalitarianism. She highlights relational egalitarianism's concern with relations of equality in 'authority, status, or standing' (Anderson 2010a, 1) and locates the fundamental disagreement between relational egalitarians and luck egalitarians in how they think about justifying principles of justice: the former demand 'interpersonal' justification, the latter 'third-person' justification. That is, while luck egalitarians consider situations just or unjust in reference to principles that objectively describe what would be just, relational egalitarians judge a situation to be just or unjust in reference to principles that every actor related to that situation can agree to as a free, equal and reasonable agent.

To contrast relational egalitarian to luck egalitarian views is very much in line with emphasising processes and procedures rather than distributions or outcomes. For luck egalitarianism's concern with just processes is generally limited to the question of whether an outcome – e.g. in wealth, in health – is or is not the result of an individual's free choice and shows little interest in how outcomes are related to broader social structures or to the actions of others.

At the same time we can see that, with Anderson's characterisation, a whole scale of theories of justice qualify for the label 'relational egalitarianist' if they rely on interpersonal justification. This may explain why in recent discussions about relational equality a gamut of views is distinguished. Voigt & Wester (2015) observe for instance two relational foci: a focus on equal relations between individual citizens, such as most prominent in the writings of Anderson (e.g. 1999) and Scheffler (e.g. 2003). And a focus on how institutions treat individual citizens, which they identify in the work by Pogge (e.g. 2006). Kelleher (2016) discerns even three strands in relational egalitarian thinking: 'equality of treatment', 'equality of concern' and 'social egalitarianism'. As Kelleher (2016) shows, these concerns are not competitive, but they complement each other by indicating different forms of relational injustice.

Relational equality: different from **Just Health** *and* **Health Justice***?*

According to relational egalitarianism's demand of interpersonal justification, also two of the most prominent and relatively recent books on health and justice that figured in this dissertation – i.e. *Just Health* by Daniels (2008) and *Health Justice* by Venkatapuram (2011) – qualify as relational egalitarian. Both justify their theories by accounts of interpersonal justification. Venkatapuram for instance, relies on Nussbaum's account of political justification in justifying his account of health as a meta-capability. Nussbaum's account resembles Rawlsian justification in the sense that it refers to 'a dialectical process of reasoning' (Venkatapuram 2011, 146) that ultimately results in an overlapping consensus about what principles should be guiding when achieving social justice. Also, Daniels – by extending Rawls's theory – assigns great weight to the importance of interpersonal justification for justice by arguing for the 'accountability for reasonableness' as a demand of – for instance – fair resource allocation in health care (e.g. Daniels 2008, 117-140). And so, by giving public deliberation and reasoning centre stage both theories demand that their principles are interpersonally justifiable.

Still, when it comes to the question of how the opportunity to be healthy is relevant for social justice, Venkatapuram's answer as well as Daniels's answer are not typically 'relational egalitarian'. For both tend to focus on the relevance of health outcomes for the individual person, more than on the relevance of health for relations of equality. That is, according to Venkatapuram's account of a meta-capability to health, health is conceptualised as the ability to achieve the central human capabilities as listed by Nussbaum that together constitute a decent human life. As noted in chapter 5, Nussbaum's ideal of a decent human life, or a life in human dignity, steers us to focus on how a person's health relates to the quality of life of the individual person, rather than on how a person's health affects or is affected by social relations.

This focus on how a person's health affects one's quality of life is also central in Daniels's account. For by broadening Rawls's opportunity principle, he argues that we are entitled to the protection of normal biological functioning because we are entitled to 'a fair share in the normal opportunity range', such that we can pursue life plans that we find 'satisfying or otherwise happiness producing' (Daniels 2008, 35). From a relational egalitarian perspective, justifying this expansion of the opportunity principle by reference to prospects on happiness and wellbeing is questionable, because 'happiness' or 'satisfying life plans' are arguably an unsatisfactory answer to the question of what we owe to each other. That is, relational egalitarians should condemn situations in which some people are thwarted by others in their pursuit of happiness, the relational egalitarian ideal of equal standing does not *require* happiness. So, in spite of his Rawlsian legacy, Daniels's broadened opportunity principle distracts from the relevance of health for relations of equality.

Now, the idea that health contributes to a person's opportunities and wellbeing is important. And it would thus be odd to ignore this clear and immediate link between health and personal wellbeing if we are interested in the relevance of health for social justice. Yet, ignoring this link is what I have – to some extent – done in the chapters on justice evaluations. That is, while acknowledging health to be important for wellbeing and opportunities, I have focused on the role of health in social relations. The perspective of relational equality helps to bring into view perhaps less obvious – though for social justice crucial – issues that come with systematic inequalities in health, such as how inequalities in health are linked with oppressive relationships, stigmatisation and unequal standing.

Relational equality: demanding too little?

That the perspective of relational equality helps to indicate the less obvious injustices of health inequalities also indicates that the perspective provides a rather thorough 'test' for the (in)justice of health inequalities. That is, since health is a good of which we cannot always immediately see if and how it affects or is affected by social relations, the question how inequalities in health are relevant for justice is not easily answered. Although I have considered this as an advantage because it stimulates critical examination, one could wonder whether relational egalitarianism is not demanding too little.

Whereas Daniels's adjustment of Rawls's theory seems to lose sight of the aspiration of relations of equality or 'democratic equality', Anderson's defence of democratic equality arguably suffers from a blind spot for the relevance of health. For instance, Segall (2009) argues that democratic equality

> *'is compatible with no provision of healthcare whatsoever (provided its absence renders everyone equally ill)'* (Segall 2009, 38)

This worry can be easily taken away. At least if we consider societies that provide accessible health care for all, relational egalitarians should not allow for unequal access to health care, as this would imply unequal treatment. Kelleher (2016) speaks here of 'equality of concern': the demand that a state treats its citizens as being of equal moral importance. Anderson (1999, 330-331) also explains a state's duty to provide medical help as a matter of respecting each citizen's life as being worthy of concern. Moreover, relational egalitarians may object to big differences in the quality of health care if this would lead to inequalities in equal standing in society. For instance, if the health care system that is accessible for all is austere, while there is extensive private healthcare only accessible to the economically best-off, this cannot be justified if this results in health inequalities that severely diminish the chance of some groups to equal standing in the system of labour (cf. chapter 7).

But arguments like these only hold in relatively developed societies. More challenging is therefore another concern raised by Segall, who further criticises Anderson's approach for under-appreciating absolute levels of wellbeing. He thereby quotes Richard Arneson, who states:

> *'Whatever exactly participation as equals requires, it evidently does not require much by way of a desirable quality of life. We could function as democratic equals while life is bleak, even squalid for all of us.'* (Richard Arneson, quoted by Segall 2009, 38)

It is indeed not evident how relational egalitarians should evaluate situations in which 'life is bleak, even squalid for all of us'. The crucial question for relational egalitarians is whether such situations are the result of other relational injustices, such as of a corrupt government that neglects the health of its entire population. If that is the case, we could speak of an injustice. But we should also note that this would not be a situation in which *everyone* has a miserable life, if the members of a government that neglects the wellbeing of its people can enjoy a higher quality of life. This points out the rigid conception of justice for relational egalitarians: to speak of injustice, there must be a situation of *some* inequality between people. And so, it seems true that absolute levels of wellbeing cannot form an issue of justice. But why should they? If we consider the fact that in a globalized world, our actions are all strongly related via social and economic processes and structures, so that the miserable lives of some mostly benefit the lives of others (cf. Pogge 2002, 127; Young 2006b). Situations in which this is not the case are hard to imagine, if not inconceivable. In other words, the situation Arneson describes likely requires an apocalypse to occur.

But still, one may wonder whether Anderson's position isn't too harsh regarding health. For it is true that we can all function as equals in a democratic state while not having the same prospects on health, since health is only taken to be of instrumental value and not as a capability that demands protection for its own sake. To this there are at least two responses. Firstly, to take the instrumental value of health as the only relevant factor for judgments of justice, is not to deny that health may also have intrinsic value, but to say that concerns of justice *differ* from concerns of wellbeing. Therefore, to have worse health prospects than others, is – according to a relational egalitarianist – not a concern of justice per se. Secondly, as discussed in chapters 6 and 7, because of the *instrumental* value of health, we have good reasons to be concerned with systematic inequalities in health, like socioeconomic health inequalities. This is so because socioeconomic inequalities in health appear to reflect oppressive social structures in which lower socioeconomic groups are systematically disadvantaged in several respects, such as in mental and physical health. And because socioeconomic inequalities in health *result* in relational injustices, such as in unequal risks to (further) marginalisation and to stigmatisation.

Lastly, Voigt & Wester (2015) point out that relational egalitarians – by focusing more on relations than on distributive outcomes – generally have not much reason to object to socioeconomic inequalities. And so, evaluating health inequalities by evaluating income inequalities – would unlikely result in judging them unjust. While Anderson's position may at first instance appear to demand little in terms of constraining inequality in wealth and income, Anderson *does* argue that too much socioeconomic inequality may lead to oppressive relationships (Anderson 1999). Similarly, Scheffler (2003) argues that significant distributive inequalities can generate inequalities in power and status. In addition, Schemmel (2011) points out that (relative) equality in e.g. income is a form of expressing equal respect.

All in all, it seems that if we thoroughly scrutinise the causes and consequences of inequalities in goods that have an instrumental value for relational equality, as well as concerns of expressing equal respect, relational equality *is* a demanding ideal.

Personal responsibility for health

Since a great part of socioeconomic inequalities in health are due to health-damaging behaviours, the topic of personal responsibility for health might be seen as ‘the elephant in the room’ in this dissertation. Except for the remarks in chapter 6, I have been basically silent on this. Arguably, this is in ‘good’ tradition of relational egalitarians, who have been criticised for assigning insufficient importance to personal responsibility (e.g. Schmidt 2009; Segall 2009, 37-44).

When aspiring to a society of equals, the challenge for public health policies is to find a balance between respecting people as agents, while acknowledging people’s embeddedness in social structures. In this regard, as noted by Voigt & Wester (2015), the perspective of relational equality may actually have something important to add to discussions about health and justice, given its focus on respect and equal standing. For public health policies are not only to be assessed on what effects they have on health levels, but also on how they treat citizens. Paternalistic interventions – suggesting a lack of prudence, rationality or other deficiency at the side of those subjected to the intervention – do not fit well with respecting citizens as equals (Voigt & Wester 2015, 24-27). But leaving everything up to the individual – thereby *overestimating* people’s ability to act prudently and rational – may just as well lead to disrespect. After all, an emphasis on individual responsibility will easily lead to negative moral judgements of imprudent or irrational behaviour. For if everyone is held responsible for his or her own health, this comes with the expectation that each person can and will take care of him or herself. Failing to do so may not be acknowledged as an inability, but be taken as unwillingness to do so, and thus as condemnable (cf. chapter 7). Or otherwise as giving support to the claim that people who get ill should pay for their own health care. The challenge for public health policy is thus to treat people as agents while acknowledging their dependencies.

This demands that a balance is found between individual and social responsibility for health. This need not be an either/or question (cf. Verweij 2014). For instance, according to Young's understanding of structural injustice, the individual that suffers a structural injustice is conceived of as partly upholding the oppressive structures she is subjected to (e.g. Young 2003; 2011). For instance, a person who suffers respiratory problems due to smoking contributes to a flourishing tobacco industry by regularly buying cigarettes, and she also upholds the social norms that render smoking an acceptable practice. Because smoking is addictive, and social norms may be equally pressing on her, it would be immoral to blame this person for her respiratory problems, for instance by denying her the health care she needs. For relational egalitarians, the question of personal responsibility for health is ultimately what could be reasonably expected from the individual person in terms of behaving healthily. However, if we consider that structural injustices like socioeconomic health inequalities require political – that is, shared – responsibility to be addressed, victims of structural injustice are not to be overlooked in this. As Young argues, a conception of political responsibility takes it that:

> *'those who can properly be argued to be victims of structural injustice can be called to a responsibility that they share with others in the structures to engage in actions directed at transforming the structures.'* (Young 2003, 15)

Following Young, what exactly can be expected from lower socioeconomic groups in changing behaviour and/or in changing the social structures that induce health-damaging behaviour depends upon degrees of 'connection, power, privilege, and interest' (Young 2003, 17). That is, degrees of responsibility depend on the degrees of being connected to the structures that bring about injustice, degrees of power and influence to change the structures, degrees of privileges enjoyed by the existence of structures and degrees of interest in the existence of social structures.

How this political responsibility would work out exactly is up to further investigation, which requires empirical insight in the social mechanisms leading to socioeconomic health inequalities and their persistence. But it appears that individual and governmental responsibility can complement each other, and that other (private and public) actors – e.g. cigarette and food companies, housing associations, employers – likely have a role to play too (cf. Tempels et al. 2017). Moreover, we can see that the idea of political responsibility for socioeconomic health inequalities is tightly related to the concern of recognition of lower socioeconomic groups in aspirations to health equity (cf. chapter 4; Blacksher 2012, 2018). For taking the ideal of a society of equals seriously implies that lower socioeconomic groups are not merely victims of structural injustices but are to be recognised as agents as well.

III. Recommendations for policy and further research

Before concluding with the implications for policymakers and directions for future research, I briefly discuss the question of which health measures to focus upon, considering the analyses of justice evaluations of the second part of this dissertation. The answer to this question already entails some indications for further research and policy-focus.

What can justice evaluations tell us about the relevance of different health measures?

While chapter 4 argued that both subjective and objective health measures likely have their relevance, we may now wonder whether the discussions on justice evaluations have given reason to focus more on inequalities in some measures than in others. I will hereby look at the five health indicators that are commonly used in the Netherlands: that is, in life expectancy, life expectancy without chronic disease, life expectancy without (physical) disability, life expectancy in good mental health and life expectancy in as good perceived health. Although chapter 5 does not give reason to think that we can define non-arbitrary thresholds for any of these measures, chapters 6 and 7 provide some directions of thought that we could apply to these five measures in slightly different ways.

Based on chapter 6 we can say that in principle any inequalities in health matter if they are the result of social structural processes *and* come with other inequalities in wellbeing or social status. And so, since the above-mentioned indicators all reveal a social gradient, there is reason to believe that inequalities in each of these measures are unjust. That is, they correlate with socioeconomic inequalities, and social epidemiologists are making headways in explaining this correlation for each of these health measures. Still, as noted, discussing the question of political responsibility regarding socioeconomic health inequalities requires empirical insight in the specific structural processes causing them. To what extent we know enough in this regard, I simply don't know.

Chapter 7 shows that inequalities in several health indicators may threaten relational equality, understood as the ideal of a society of equals. Put positively, equality in life expectancy matters for equal prospects on pension enjoyments. And equality in life expectancy without chronic diseases, in life expectancy without disabilities, and in life expectancy in good mental health matters for equal prospects on employment status. Although not all physical and mental health problems are equally disabling, there is enough empirical evidence that inequalities in these three measures generally come with unfavourable employment prospects, such that addressing these health inequalities – *or* addressing their unjust effects is due.

Moreover, some physical diseases, disabilities and mental illnesses come with stigmatisation, and so, equality in life expectancy without these specific conditions is also a concern for people's equal standing in the sense of not being stigmatised. Although it is the inequalities in stigmatised conditions that are a specific concern for relational equality, we have shown that there is a great overlap between stigmatised conditions and diseases that are most common in lower socioeconomic groups.

Considering how health inequalities may have unjust consequences, there is one health measure – that of self-perceived health – for which it is less clear how to evaluate inequalities in that regard. That is, we do not know what it means for a person's life and his or her relations with others if she does not think of herself as being in good health. Because this self-perceived health measure is found to be a good predictor of people's objective health status, this might be a hypothetical question: it is likely that the perception of being in poor health corresponds with being in poor health objectively speaking. Still, it is an interesting question whether the *mere perception of being in poor health – or being less healthy than others* could have effects that are relevant for justice. For instance, if the perception of being in poor health affects one's sense of autonomy or one's self-efficacy, equality in as good perceived health would be relevant for equal prospects on several capabilities needed to function as an individual agent. And to the extent that being in good health functions as a status symbol, not feeling healthy may affect one sense of self-worth and self-respect, which is also crucial for several capabilities needed to live on equal standing.

Lastly, in addition to the effects on employment-prospects and on stigmatisation, health inequalities could have other effects that are relevant for social justice that chapter 7 has not considered. For instance, we could also study the effects of inequalities in childhood health on educational opportunities, or the effects of inequalities in disability free life years on participation in public life (voting, media use, etc.).

So, even though we might not know enough to give a well-informed answer to the question of who are responsible to reduce them, there is a social gradient in each of these health measures. Also, while this is not immediately clear for the measure of self-perceived health, inequalities in the other indicators clearly have effects that are relevant for social justice. We can thus definitely conclude that inequalities in (almost) all of the here discussed and commonly used indicators of health are relevant for justice.

Recommendations for policy and research

The findings as summarised in this chapter can be translated into the following recommendations for health equity policies and future research:

- Policymakers in public health have good reason to take into account the views on health of lower socioeconomic groups to ensure that these groups do not suffer misrecognition. That is, persons of lower socioeconomic groups should be recognised as participants in both the social structures that result into health inequalities, and in the policies to address these inequalities.Social scientists, such as those working in the field of (medical) sociology, can contribute to this by providing insights in the perspectives, values and experiences prevailing in these groups regarding health, and regarding specific public health policies.
- Politicians and policymakers should – when addressing unjust health inequalities by considering their causes – also consider and discuss what can be expected from non-governmental actors that uphold the social structures that lead to systematic health inequalities, such as housing associations, food companies, and employers of non-professional workers or lower income jobs. Social epidemiologists can inform these discussions further by providing insight in what exactly the relevant and most influential actors are in the emergence of socioeconomic health inequalities. For instance, by focusing on health deprivations and their explanatory factors in specific social groups, such as in specific neighbourhoods, or among unemployed people, or people with specific jobs.
- Politicians and policymakers should – apart from the social determinants of health – consider what consequences inequalities in health have for the ideal of a society of free and equals and discuss ways to mitigate potential unjust effects of persistent health inequalities. Options that can already be said to deserve attention are the flexibilization of retirement age, flexible working conditions for chronically ill employees and actions to minimize health related stigmatisation. Social scientists – e.g. in the field of social epidemiology, (social)psychology, and in the sociology of labour – help to indicate

further priorities as they offer knowledge of the specific effects of inequalities in different health measures on people's wellbeing and social standing.

- In both policy and research, extra attention should be paid to groups where health deprivations cluster with other disadvantages, as in these groups health problems are most disabling and most likely to come with stigmatisation.

In this dissertation I have applied philosophical theories about health and social justice on the phenomenon of socioeconomic health inequalities. My aim has thereby been to pay due attention to what is known about these inequalities, such that the normative analyses are aligned with empirical knowledge. While there are still questions regarding responsibilities for health, it is clear that socioeconomic health inequalities demand action. Whether this should be done in terms of reducing the inequalities in health themselves, or in terms of mitigating their unjust effects is – in my view – to be decided in light of what the ideal of a society of equals suits best.

Notes

1. My proposed view on health concepts has also much in common with Schwarz's (2014) proposal to turn philosophical debates about the meaning of terms like health, disease and function towards *philosophical explication*, instead of pursuing *conceptual analysis*. That is, rather than 'discovering' the meaning of these terms, philosophers should describe how these terms are to be used in a given context. However, I think that this explication is not up to philosophers alone and can often be fruitfully informed by e.g. health care practitioners, citizens or medical scientists.

2. To see what a study to the robustness of Nussbaum's list could look like, see Wolff & De-Shalitt (2007). In the Netherlands, the study by Huber et al. (2016) arguably illustrates what an investigation of society-wide values, specifically in relation to health, could entail.

3. It should be noted that most of the commonly used indicators focus on what is mostly referred to 'negative' health aspects (i.e. the absence of health

problems). Therefore, arguably ‘positive’ health aspects (i.e. the presence of feelings like ‘feeling energetic’ ‘being in control’, ‘lust for life’, etc.) should be investigated. However, from the perspective of health justice and recognition there is no reason to do so, given that the concept map study showed that these positive health aspects were primarily central to health concepts of the higher socioeconomic groups.

4. In this regard, I thus concur with the WRR policy advice to give extra attention to the groups with the greatest needs (Broeders et al. 2018). However, as the report also argues to shift the focus from reducing inequalities to utilising ‘the health potential’ in the whole population, this advice may also be interpreted as a justification of threshold fetishism. This is a defensible approach, because cost-effectiveness and efficiency are also morally relevant considerations, but it would – all things being equal – not be the most *just* approach.

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Summary

That there is a strong correlation between people's socioeconomic position and health within high income countries is a well-documented fact. A person's occupation, income and education level tell us a lot about that person's prospects on a long and healthy life, such that we can speak of a 'social gradient in health', or a 'socioeconomic health gap'. This association between health and socioeconomic position is often perceived to be unjust. Therefore, socioeconomic inequalities are generally thought of as inequalities that governments should aim to reduce.

However, this idea needs further ethical justification, for it is not evident if and why *exactly* these inequalities are unjust. For instance, are inequalities in health unjust per se? Or because the underlying socioeconomic inequalities are unjust? And does justice require equal health levels, or a minimum level of health?

What complicates the issue further, is that the width of the health gap, or the steepness of the social gradient, depends on what health measures are used. Overall, the more subjective the measure, the greater the inequalities appear to be. But are all these measures equally morally relevant?

This dissertation aims to get a better understanding of these philosophical questions. It does so by investigating the question of what we should understand by health in the first part (chapters 2-4), after which it addresses the question of how to evaluate socioeconomic health inequalities in the light of justice (chapters 5-7).

Chapter 1 Introduction

The introductory chapter begins with a description of the phenomenon of socioeconomic inequalities in health in high income countries, and how it has (or has not) been addressed by politicians, epidemiologists and philosophers in the past and today. This historical overview shows that 1) while socioeconomic health disparities are known to exist since ages, it is only for a number of decades that politicians and policymakers have formulated ambitions to reduce them, though with little success; 2) that epidemiologists overall agree that socioeconomic position primarily determines health status, rather than the other way around, but they are still searching for the ultimate explanation of their persistence; and 3) that philosophers tend to agree that socioeconomic health inequalities raise concerns of social justice, and that the philosophical dispute is about the question of how exactly to evaluate them: as an independent concern of justice, or as a derivative concern of socioeconomic justice.

The chapter continues by formulating the central question of the dissertation – that of which health inequalities should be focused in the light of a concern with social justice. It explicates how this dissertation contributes to answering that question, by discussing the potential relation between the conceptualisation of health (part 1) and justice evaluations (part 2), and by discussing which questions are addressed in each of the following chapters.

Chapter 2 A practice-oriented review of health concepts

This chapter addresses the question of how health is conceptualised in the philosophical and public heath literature, and how theoretical concepts of health differ. It proposes to approach health concepts as a Wittgensteinian family of thick concepts and argues that while theories on health generally argue in favour of one specific concept, a comparison of concepts shows that we may need different concepts of health given the variety of health practices.

It argues for this by discussing five health concepts: three philosophical concepts – the ones by Boorse, Nordenfelt and Venkatapuram – that also figure in contemporary (analytical) debates about health and justice, and two policy-oriented concepts: the WHO-definition of health, and Huber et al.'s more recently proposed alternative.

By explicating the differences between these five concepts of health, this chapter argues that each captures aspects of health that all seem relevant when we talk and think about health. Classifying these concepts based on their distinctions reveals them as members of a conceptual family: each of the discussed concepts differs from the others in at least one respect and resembles the others in several respects. Moreover, the discussion of the concepts shows that 'health' always both describes a condition and values that condition at the same time. Having both descriptive and evaluative dimensions, we can see health concepts as 'thick concepts'.

It is argued that given this evaluative dimension, it is important to reflect on the question of what understanding of health guides specific practices. Moreover, the distinctions revealed by the classification are proposed to serve as a conceptual toolbox for reflection on the assumptions and purposes of particular health practices. How such reflection could work is illustrated by a brief exploration of what health aspects are focused upon in three specific health practices: biomedical research, care for chronically ill patients and public policies concerned with health inequities.

Chapter 3 Do conceptualisations of health differ across social strata? A concept mapping study among lay people

Because we may wonder why it should be up to philosophers or health experts what health means, this chapter presents a small-scale empirical study into the question of how health is conceptualised by ordinary citizens and to what extent conceptualisations of health differ between socioeconomic groups. By making use of the method of concept mapping, this study analyses how different socioeconomic groups – defined by education level – formulate their own answers regarding the question 'what does health mean to you?'.

It presents concept maps of health for three different socioeconomic groups living in the city of Utrecht that reveal that all groups have a multidimensional understanding of health. That is, each group takes 'absence of disease and disabilities', 'health-related behaviour', 'social life', and 'attitude towards life' as aspects of health.

An interpretation of the concept maps reveals nuanced differences between groups: health-related behaviours were primarily framed in terms of having *opportunities* to behave healthily in the lower educated group, and in terms of the *impact* of behaviour on health in the higher educated group. Besides, 'autonomy and independence' appeared to be an aspect of health according to the higher and intermediately educated group, but not according the lower socioeconomic group.

The aspects of health were also ranked by importance. Here it appeared that the higher socioeconomic group assigned more importance to positively formulated aspects (e.g. 'lust for life'), whereas lower socioeconomic groups ranked negatively formulated aspects higher (e.g. 'having no chronic disease'). Each group assigned most importance to mental health.

All in all, the study shows that people in lower socioeconomic groups are more likely to show a conceptualisation of health that refers to 1) the absence of health threats (*versus* positive aspects), 2) a person within his/her circumstances (*versus* quality of own body/mind), 3) the value of functional (*versus* hedonistic) notions, and 4) an accepting (*versus* active) attitude towards life.

Chapter 4 From health to justice. The relevance of health concepts in the light of justice

This chapter addresses the question of what the theoretical and empirical study to concepts of health could imply for health equity practices. It does so by exploring further the suggestions made in chapters 2 and 3. Respectively, that in different practices, different aspects of health should be guiding, and that the views and concepts of health by ordinary citizens should be taken into account when forming public health policies.

Regarding the question of which health aspects should guide health equity policies, this chapter focuses on the question of whether we should primarily look at subjective or objective health measures, and of whether a universal or relative standard of health should be central. While justice-related concerns of impartiality and equal treatment may seem to favour an objective perspective and a universal health standard, it appears that we have good reason to take into account the subjective perspective as well.

Besides, it is argued that because of a concern for recognition and participatory parity, a case can be made for relative health standards, by taking up the suggestion that citizen's views of health should be considered in public policy formation. While this pleads for some room for relative health standards, it also confronts us with the question of how to deal with mechanisms like adaptative preferences that the concept maps reveal. It proposes a way out, by arguing that society-relative health standards could be relied upon that go beyond distinct standards prevailing in different socioeconomic groups.

The conclusion of this chapter is that the conceptual studies per se do not provide reasons to focus more on inequalities in some health measures than in others, and that there are good reasons to take subjective health measures into account as well.

Chapter 5 Can we be healthy enough? Evaluating health inequalities from a sufficientarian perspective

This chapter examines the question of whether inequalities in health should be evaluated 'directly', meaning that they are judged to be just or unjust, independently of a distribution of their social determinants. It proposes that a plausible way to do so is by endorsing a sufficientarian perspective, such that the central question of evaluation is that of whether everyone is – or can be – healthy enough.

By discussing two sufficientarian approaches to health and social justice – the one by Powers & Faden and the one by Nussbaum – this chapter distinguishes two ways of setting a threshold level for health. A first is to base a minimum for health in reference to what health levels are achievable – or put negatively, what health deprivations are avoidable, in a given society (a 'contextualist' approach); a second is to derive a health minimum from an external criterion, such as 'a decent human life', or 'a life in human dignity' (an 'external' approach).

Both approaches appear to provide an unsatisfactory basis for justice evaluations and lead us away from direct evaluation if we try to settle health minima that are less arbitrary. For the first approach, a satisfactory moral basis of a health threshold comes down to the question of what health deprivations a society is due to avoid. The second approach could come to a non-arbitrary understanding of sufficient health if it takes into account the ways in which health interacts with social and material circumstances, and thus considers the practical consequences of health deprivations.

In anticipation to chapters 6 and 7, it is argued that the perspective of relational equality compared to that of a decent human life better helps to answer both the question of what socioeconomic health inequalities a society is due to avoid, and the question of when socioeconomic health inequalities are unjust considering their consequences.

Chapter 6 Broadening the Rawlsian scope of justice to incorporate the complexity of the social determinants of health

Taking up the question of what health inequalities a society is due to avoid, this chapter discusses to what extent Daniels's theory of health justice provides a satisfactory answer to this question. Daniels proposes an indirect evaluative approach by arguing that we should evaluate socioeconomic health inequalities in the light of Rawls's principles of justice as fairness. That is, if socioeconomic inequalities are in accordance with fair equality of opportunity and with the difference principle, the corresponding health inequalities would be just.

This chapter shows that the suggestion that Rawls's principles regulate the social determinants of health neglects that not all social determinants of health belong to society's basic structure as conceived of by Rawls and are thereby not subjected to the principles of justice. To acknowledge the social mechanisms leading to socioeconomic health inequalities in their full complexity, it is argued that we should broaden our understanding of society's structure in accordance with Young's notion of social structural processes. This renders the question of what health inequalities a society is due to avoid into a question of what we can expect from the side of the various actors that uphold the social structures that produce socioeconomic health inequalities.

This chapter ends by a brief reflection on how a shift to Young's theory completes the shift to non-ideal theorising that seem already initiated by Daniels, and that with this, the distinction between direct and indirect evaluation dissolves.

Chapter 7 Why socioeconomic inequalities in health threaten relational justice. A proposal for an instrumental evaluation

The central question of this chapter is to what extent equality in health is of instrumental value for a society of free and equals. It thus takes up the idea proposed in chapter 5, that apart from evaluating the causes and the social determinants of health inequalities, an evaluation of the consequences of health inequalities is due.

The ideal of relational equality is thereby endorsed as an evaluative framework, and this chapter discusses three ways in which inequalities in (healthy) life expectancy threaten this ideal. That is, via unequal risks to stigmatisation, unequal risks to unemployment and the risk of unequal pension enjoyments. It is thereby shown that these risks are especially great for those lower down the socioeconomic strata. It is thus concluded that equality in health is of instrumental value to relational equality, and that socioeconomic health inequalities may not only be unjust due to their causes, but also because of their consequences.

The chapter continues to argue that our instrumental approach opens a new perspective, namely to mitigate the identified injustices by changing society, rather than by reducing inequalities in health. This is argued to be an advantage in the light of the realistic assumption that (part) of the socioeconomic health inequalities will persist. The paper thus offers a complementary approach to both the evaluation and the mitigation of the injustice of socioeconomic inequalities in health.

Chapter 8 Discussion

This chapter summarises the central findings of the analyses of health concepts and discusses questions regarding the philosophical and practical merits of comparing theoretical health concepts, the need for developing new health measures or concepts and the importance or nonsense of studying citizen's views on health. Repeating this for the dissertation's second part, the central findings of the chapters on justice evaluation are summarised and followed by a discussion of questions and issues that have remained unaddressed so far. Here, central points of discussion are my take on rules of distribution, the distinction of direct and indirect evaluation, the role of ideal and non-ideal theory, the idea of relational equality, and personal responsibility for health.

This chapter concludes by noting that also in the light of justice evaluations, all commonly used health measures are relevant for justice. Therefore, my recommendations for policy and further research entail that inequalities in each of these measures deserve attention by both policymakers and researchers. Specifically, policymakers and researchers should give attention to how exactly each of these health inequalities come about, in such a way that a discussion about the question of who can be assigned responsibility to alleviate them is well-informed; and both should give attention to the effects of health inequalities on the opportunities for people to live on equal standing, in such a way that when these opportunities are diminished, actions can be considered to aim to restore relational equality.

Samenvatting

De sterke correlatie tussen sociaaleconomische positie en gezondheid in hoge inkomenslanden is een alom bekend fenomeen. Iemands beroep, inkomen en onderwijsniveau zeggen veel over iemands kansen op een lang en gezond leven: hoe hoger je positie op de sociaaleconomische ladder, hoe beter je kansen in dit opzicht zijn. Er wordt dan ook wel gesproken van een 'sociale gradient in gezondheid' of van een 'sociaaleconomische gezondheidskloof'. Deze sociaaleconomische verschillen in gezondheid worden doorgaans als onrechtvaardig beschouwd, en dus als verschillen die overheden moeten proberen te verkleinen.

De gedachte dat deze verschillen onrechtvaardig zijn vraagt echter om verdere ethische onderbouwing. Het is namelijk niet duidelijk *of* en zo ja *waarom* deze verschillen precies onrechtvaardig zijn. Zijn verschillen in gezondheid bijvoorbeeld onrechtvaardig als zodanig, of omdat de onderliggende ongelijkheden onrechtvaardig zijn? En is het onrechtvaardig dat niet iedereen *gelijke* kansen op gezondheid heeft, of dat niet iedereen de kans heeft op een bepaald *minimum* gezondheidsniveau?

Wat de kwestie verder compliceert is dat het afhangt van de gebruikte maat of indicator van gezondheid hoe groot de verschillen zijn. In het algemeen geldt dat het gebruik van subjectieve maten ('ervaren' gezondheid) grotere verschillen laat zien dan het gebruik van meer objectieve maten ('meetbare' gezondheid). Dit roept de vraag op of al deze gezondheidsmaten even relevant zijn voor rechtvaardigheidsoordelen.

Dit proefschrift beoogt meer grip te krijgen op deze filosofische vragen. Allereerst door in deel I (hoofdstukken 2 t/m 4) de vraag te bespreken wat we zouden moeten verstaan onder 'gezondheid'. Vervolgens staat in deel II (hoofdstukken 5 t/m 7) de vraag centraal hoe we sociaaleconomische gezondheidsverschillen zouden moeten beoordelen in het licht van rechtvaardigheid.

Hoofdstuk 1 Inleiding

In het inleidende hoofdstuk beschrijf ik het fenomeen sociaaleconomische gezondheidsverschillen in hoge inkomenslanden, en hoe dit in het verleden al dan niet geproblematiseerd is door politici, epidemiologen en filosofen. Deze beknopte historische schets laat ten eerste zien dat hoewel sociaaleconomische verschillen in gezondheid een eeuwenoud verschijnsel zijn, politici en beleidsmakers pas sinds enkele decennia ambities uitspreken om deze verschillen te verkleinen. Ten tweede blijkt dat epidemiologen het erover eens zijn dat sociaaleconomische positie hoofdzakelijk gezondheid bepaalt (meer dan andersom), maar dat er tegelijkertijd nog geen ultieme verklaring is voor de hardnekkigheid van deze verschillen. Ten derde toont dit overzicht dat filosofen en ethici over het algemeen geneigd zijn sociaaleconomische gezondheidsverschillen te problematiseren in het licht van sociale rechtvaardigheid, terwijl er onenigheid bestaat over *hoe* we ze precies moeten beoordelen: ‘direct’ – als een opzichzelfstaand onrecht – of ‘indirect’ – als een afgeleide van sociaaleconomisch onrecht.

In dit hoofdstuk formuleer ik de centrale onderzoeksvraag als volgt: welke gezondheidsverschillen verdienen precies onze aandacht in het licht van sociale rechtvaardigheid? Vervolgens expliciteer ik de deelvragen die centraal staan in de vervolghoofdstukken, en maak ik duidelijk hoe beantwoording van deze deelvragen bijdraagt aan een antwoord op de centrale onderzoeksvraag.

Hoofdstuk 2 Een praktijkgerichte beoordeling van gezondheidsconcepten

In dit hoofdstuk bespreek ik de vraag hoe gezondheid geconceptualiseerd is in filosofische en meer praktische volksgezondheidsliteratuur, en hoe theoretische concepten van gezondheid verschillen. Ik stel voor om concepten van gezondheid op te vatten als een Wittgensteiniaanse familie van zogenaamde ‘thick concepts’. Daarmee pleit ik ervoor om niet te streven naar één perfecte theorie van gezondheid, maar om per (gezondheidsbevorderende) praktijk na te gaan wat we zouden moeten verstaan onder gezondheid.

Dit perspectief maak ik plausibel door een bespreking en analyse van vijf gezondheidsbegrippen: drie filosofische – die van Boorse, Nordenfelt en Venkatapuram – die een rol spelen in discussies over gezondheid en rechtvaardigheid; en twee gezondheidsbegrippen uit de beleidspraktijk: de definitie van de Wereldgezondheidsorganisatie en het door een aantal gezondheidsexperts meer recent voorgestelde alternatieve begrip van positieve gezondheid.

Door de verschillen tussen deze vijf concepten te expliciteren, hoop ik duidelijk te maken dat elk van deze begrippen aspecten van gezondheid weten te vatten die relevant lijken als we spreken en denken over 'gezond zijn'. Als we deze begrippen classificeren op basis van hun onderlinge verschillen, kunnen we ze zien als leden van een begrippenfamilie. Elk van de besproken concepten verschilt van de andere in tenminste één opzicht, en komt overeen met de andere in verschillende opzichten. Bovendien laat ik met de bespreking van deze vijf begrippen zien hoe 'gezond' altijd zowel een beschrijving als een waardering van een bepaalde toestand geeft. Door deze descriptieve én evaluatieve dimensie kunnen we gezondheid zien als wat sommige filosofen een 'thick concept' noemen.

Het is de evaluatieve dimensie van de term 'gezond' die maakt dat reflectie van belang is op de vraag welk begrip van gezondheid leidend is in specifieke gezondheidsbevorderende praktijken. Dergelijke reflectie kan gebaat zijn bij inzicht in alternatieve gezondheidsbegrippen, bijvoorbeeld zoals die hier besproken. Hoe dit in zijn werk zou kunnen gaan illustreer ik met een korte bespreking van drie praktijken van gezondheidsbevordering: biomedisch onderzoek, zorg voor chronisch zieken en volksgezondheidsbeleid ter verkleining van gezondheidsverschillen.

Hoofdstuk 3 Verschillen conceptualiseringen van gezondheid tussen verschillende sociaaleconomische groepen? Een concept mapping studie

Omdat we ons kunnen afvragen waarom het aan filosofen of gezondheidsexperts zou zijn wat wordt verstaan onder 'gezond zijn', presenteert dit hoofdstuk een kleinschalige studie naar de vraag wat gezondheid betekent volgens 'gewone' burgers, en of en hoe opvattingen hierover verschillen tussen verschillende sociaaleconomische groepen. Middels de methode van 'concept mapping' is geanalyseerd hoe mensen uit verschillende sociaaleconomische groepen (ingedeeld naar opleiding) antwoord geven op de vraag 'wat betekent gezondheid volgens jou?'.

De studie toont conceptuele kaarten ('concept maps') voor drie verschillende sociaaleconomische groepen woonachtig in de stad Utrecht. Daaruit blijkt dat elke groep een multidimensionaal gezondheidsbegrip heeft, in de zin dat iedere groep gezondheid beschrijft als een zaak van 'afwezigheid van ziekte en beperkingen', 'gezondheidsgerelateerd gedrag', 'sociaal leven' en 'levenshouding'.

Verdere interpretatie van deze concept maps maakt genuanceerde verschillen tussen de drie groepen zichtbaar. Zo beschrijft de laagste sociaaleconomische groep gezondheidsgerelateerd gedrag vooral in termen van de *mogelijkheid* hebben om gezond te leven, terwijl de hoogste sociaaleconomische groep vooral spreekt in termen van de *invloed* van gedrag op gezondheid. Bovendien blijkt 'autonomie en onafhankelijkheid' een aspect van gezondheid te zijn volgens de middelste en hoogste sociaaleconomische groep, maar niet volgens de laagste sociaaleconomische groep.

In deze studie werden de verschillende gezondheidsaspecten ook gerangschikt naar belang. Hierbij blijkt de hoogste sociaaleconomische groep het meeste belang toe te kennen aan positief geformuleerde kenmerken (bijv. 'levenslust'), terwijl de laagste sociaaleconomische groep meer belang toekent aan negatief geformuleerde kenmerken (bijv. 'geen chronische ziekte hebben'). Alle drie de groepen kennen het meeste belang toe aan mentale gezondheid.

De conclusie van deze studie is dat mensen in een lagere sociaaleconomische positie meer geneigd lijken gezondheid te begrijpen in termen van 1) de afwezigheid van gezondheidsrisico's (*versus* de aanwezigheid van positieve ervaringen), 2) een persoon én haar omstandigheden (*versus* enkel lichaam en geest), 3) functionele (*versus* hedonistische) begrippen, en 4) een accepterende (*versus* actieve) levenshouding.

Hoofdstuk 4 Van gezondheid naar rechtvaardigheid. De relevantie van gezondheidsconcepten in het licht van rechtvaardigheid

In dit hoofdstuk behandel ik de vraag hoe de theoretische en empirische studie naar gezondheidsconcepten relevant kunnen zijn voor het streven naar sociale rechtvaardigheid op het gebied van gezondheid. Dit doe ik door de in hoofdstuk 2 en in hoofdstuk 3 gedane voorstellen verder te onderzoeken: ten eerste het idee uit hoofdstuk 2 dat in verschillende praktijken verschillende aspecten van gezondheid richtinggevend kunnen zijn; ten tweede de suggestie uit hoofdstuk 3 dat beleidsmakers ook moeten kijken naar de visies op gezondheid onder 'gewone' burgers wanneer zij volksgezondheidsbeleid maken.

Wat betreft de vraag welke aspecten van gezondheid leidend zouden moeten zijn met het oog op een rechtvaardige gezondheidsverdeling, focus ik op twee vragen: 1) kunnen subjectieve gezondheidsmaten relevant zijn als het gaat om rechtvaardigheid?; 2) vereist een streven naar rechtvaardigheid dat gezondheid altijd als een universele (in plaats van een relatieve) standaard wordt gezien?

Ik bespreek hoe de met rechtvaardigheid geassocieerde waarden van onpartijdigheid en gelijke behandeling doorgaans gepaard met een nadruk op het objectieve gezichtspunt en op universele standaarden, en maak duidelijk dat we desalniettemin goede redenen te hebben om ook naar het subjectieve perspectief – ervaren gezondheid – te kijken. Daarnaast betoog ik dat naast onpartijdigheid en gelijke behandeling, sociale erkenning, of 'participatieve gelijkheid', ook van belang is voor sociale rechtvaardigheid. Om die reden zijn in de samenleving gangbare opvattingen over gezondheid in principe relevant voor volksgezondheidsbeleid. Dit zet de deur open naar een zeker relativisme ten aanzien van de vraag wat geldt als 'gezond'.

Hoewel dit relativisme van belang kan zijn vanuit het oogpunt van sociale erkenning, confronteert het ons ook met de vraag wat te denken van mechanismen zoals 'adaptieve voorkeuren'. Eén antwoord hierop is dat relatieve standaarden acceptabel zijn voor zover ze samenlevings-breed onderschreven worden, maar problematisch worden wanneer ze gevormd worden door sociaaleconomische omstandigheden.

Voor de centrale vraag van dit proefschrift concludeer ik dat, gelet op de waarden onpartijdigheid, gelijke behandeling en participatieve gelijkheid, de studies naar gezondheidsconcepten als zodanig geen redenen bieden om meer aandacht te geven aan ongelijkheden in specifieke gezondheidsmaten dan in andere. En dat we daarom een gangbare maat als 'ervaren gezondheid' voorlopig als relevant moeten beschouwen in het licht van sociale rechtvaardigheid.

Hoofdstuk 5 Kunnen we gezond genoeg zijn? Gezondheidsverschillen beoordelen in het licht van een minimaal gezondheidsniveau

In dit hoofdstuk staat de vraag centraal of gezondheidsverschillen als zodanig, ofwel 'direct', moreel beoordeeld moeten worden, dat wil zeggen: ongeacht hoe we onderliggende sociaaleconomische verschillen beoordelen. Eén manier om dit te doen is door te kijken of de groep die het slechtst af is in termen van gezondheid nog wel een bepaald basisniveau van gezondheid behaalt. Met andere woorden: is de minst gezonde groep gezond genoeg? Als dat zo is, *zou* dat kunnen betekenen dat gezondheidsverschillen niet onrechtvaardig zijn.

De moeilijkheid van dit perspectief zit in het vaststellen van wat een basisniveau van gezondheid zou moeten zijn. Een bespreking van twee 'sufficientaristische' theorieën – die van Powers & Faden, en die van Nussbaum – tonen twee manieren om een gezondheidsminimum te bepalen. De eerste noem ik een contextuele benadering: door te kijken naar wat 'haalbaar' is in een gegeven samenleving, wordt het gezondheidsminimum bepaald door de context. De tweede noem ik een externe benadering, daar het criterium voor een gezondheidsminimum bepaald wordt door een extern moreel criterium, in het geval Nussbaum 'menswaardigheid'.

Beide benaderingen blijken een onbevredigende – want moreel willekeurige – basis te bieden voor rechtvaardigheidsoordelen. Bovendien blijkt voor beide gevallen dat als we morele redenen voor een gezondheidsminimum willen geven, we afstand doen van het idee van een directe of zelfstandige beoordeling van gezondheidsverschillen. Immers, wat ‘haalbaar’ is (de contextuele benadering) hangt af van de normatieve vraag wat een samenleving verplicht is wat betreft het voorkómen van gezondheidsproblemen. Dit betekent dat een oordeel over sociaaleconomische gezondheidsverschillen deels afhangt van hoe we onderliggende sociaaleconomische ongelijkheden beoordelen. En voor de vraag wat een ‘menswaardig’ minimum is (de externe benadering) geldt dat die niet beantwoord kan worden zonder rekenschap te geven van de praktische gevolgen van gezondheidsproblemen of -achterstanden.

Vooruitlopend op hoofdstukken 6 en 7, waarin respectievelijk de oorzaken en gevolgen van sociaaleconomische gezondheidsverschillen centraal staan, betoog ik dat het perspectief van relationele gelijkheid helpt om deze laatste twee vragen zinvol te beantwoorden.

Hoofdstuk 6 De sociale determinanten van gezondheid en het onderwerp van rechtvaardigheid: een verbreding van het Rawlsiaanse perspectief

Een antwoord op de vraag wat een samenleving verplicht is in termen van het voorkómen van gezondheidsverschillen dan wel -achterstanden kunnen we mogelijk vinden in Daniels’ theorie van gezondheid en rechtvaardigheid. Daniels stelt namelijk voor om sociaaleconomische gezondheidsverschillen te beoordelen met behulp van Rawls’ principes van rechtvaardigheid. Dit betekent dat sociaaleconomische verschillen in gezondheid rechtvaardig zijn, mits de onderliggende sociaaleconomische ongelijkheid gepaard gaat met kansengelijkheid én in het voordeel werkt van degenen die het slechtst af zijn.

In dit hoofdstuk laat ik echter zien dat Daniels’ suggestie dat Rawls’ principes de sociale determinanten van gezondheid reguleren te kort door de bocht is. Het gaat namelijk voorbij aan het feit dat lang niet alle sociale determinanten van gezondheid behoren tot wat Rawls ziet als het onderwerp van rechtvaardigheid: de basisstructuur van een samenleving. Om de complexiteit te erkennen van de maatschappelijke mechanismen die leiden tot gezondheidsverschillen, stel ik voor om het onderwerp van rechtvaardigheidsoordelen te verbreden met behulp van Youngs begrip van sociaal structurele processen.

Door sociaal structurele processen onderwerp te maken van ons rechtvaardigheidsoordeel, wordt de vraag naar wat een samenleving verplicht is in termen van het voorkómen van gezondheidsverschillen een kwestie van wat we redelijkerwijs mogen verwachten van verschillende actoren die bijdragen aan het ontstaan en voortbestaan van sociaaleconomische gezondheidsverschillen.

Ik concludeer dit hoofdstuk met een korte reflectie op hoe Youngs perspectief ook een theoretische verschuiving impliceert: van ‘ideal theory’ naar ‘non-ideal theory’. Door deze verschuiving te erkennen wordt duidelijk dat het onderscheid tussen directe en indirecte evaluatie verdwijnt.

Hoofdstuk 7 Waarom sociaaleconomische gezondheidsverschillen een gevaar zijn voor relationele gelijkheid. Een voorstel voor instrumentele evaluatie

De centrale vraag van dit hoofdstuk is in hoeverre gelijke gezondheidsniveaus bijdragen aan relaties van gelijkwaardigheid tussen burgers. Dit hoofdstuk borduurt daarmee voort op het idee dat naar voren werd gebracht in hoofdstuk 5. Namelijk dat we voor een rechtvaardigheidsoordeel niet alleen de oorzaken van verschillen in gezondheid moeten beoordelen, maar ook naar de gevolgen moeten kijken.

Het ideaal van relationele gelijkheid neem ik hierbij als normatief kader, en ik bespreek drie gevolgen van sociaaleconomische verschillen in (gezonde) levensverwachting die de realisatie van dit ideaal in de weg staan. Het eerste gevolg is ongelijkheid in risico’s op gezondheid gerelateerde stigmatisering, het tweede is ongelijkheid in risico’s op werkeloosheid, en het derde is ongelijkheid in de kans op het genieten van een (min of meer) gelijk aantal jaren pensioen. Hoewel deze risico’s opgaan voor eenieder die met gezondheidsproblemen te maken krijgt, maak ik duidelijk dat deze risico’s in het bijzonder groot zijn voor mensen die in minder gunstige sociaaleconomische omstandigheden leven. De conclusie is dus dat gelijkheid in gezondheid bijdraagt aan, ofwel van instrumentele waarde is voor, relationele gelijkheid. Dit betekent dat sociaaleconomische gezondheidsverschillen niet alleen onrechtvaardig zijn vanwege hun oorzaken, maar ook vanwege de gevolgen die ze kunnen hebben.

In aanvulling op deze conclusie, laat ik zien dat deze instrumentele kijk op gelijkheid in gezondheid een nieuw handelingsperspectief biedt. Want behalve streven naar een verkleining van gezondheidsverschillen, kunnen de drie besproken vormen van onrecht óók worden geadresseerd door veranderingen in de manier waarop we een samenleving vormgeven. Zo betoog ik dat de onrechtvaardige effecten van sociaaleconomische gezondheidsverschillen verzacht kunnen worden door stigmatisering van gezondheidsproblemen tegen te gaan, door de kans op werkeloosheid door ziekte te verkleinen, en door de pensioenleeftijd te differentiëren naar bijvoorbeeld beroep, inkomen of opleiding. Dit inzicht is van belang in het licht van de realistische verwachting dat sociaaleconomische gezondheidsverschillen ten dele zullen blijven bestaan.

Hoofdstuk 8 Discussie

Dit hoofdstuk vat de belangrijkste bevindingen samen voor elk van de twee delen van dit proefschrift. Met betrekking tot de analyses van de betekenis van gezondheid reflecteer ik nogmaals kort op de filosofische en praktische baten van een vergelijking van gezondheidsconcepten, op de eventuele nood van nieuwe gezondheidsmaten, en op het morele belang van aandacht besteden aan de onder ‘gewone’ burgers gangbare visies op gezondheid.

Met betrekking tot de analyses over rechtvaardigheidsoordelen bespreek ik hier kwesties die tot dusver enkel oppervlakkig aan bod kwamen. Namelijk hoe nu precies te denken over rechtvaardige verdelingspatronen, het onderscheid tussen directe en indirecte beoordeling, de rol van ‘ideal’ en ‘non-ideal theory’, het ideaal van relationele gelijkheid, en hoe te denken over individuele verantwoordelijkheid voor gezondheid.

Ik besluit dit discussiehoofdstuk met aanbevelingen voor beleid en vervolgonderzoek. Daarvoor concludeer ik eerst dat ook in het licht van de discussies over rechtvaardigheidsoordelen uit deel II van dit proefschrift, alle gangbare gezondheidsmaten relevant blijken voor rechtvaardigheid. En dat elk van de gebruikte gezondheidsmaten dus aandacht verdienen door zowel beleidsmakers als onderzoekers. Daarbij is het vooral van belang is om te kijken naar hoe gezondheidsverschillen – in verschillende maten – precies tot stand komen, zodat een discussie mogelijk wordt over de vraag welke actoren verantwoordelijk zijn voor het adresseren van onrechtvaardige verschillen. Daarnaast is het van belang aandacht te besteden aan de manieren waarop gezondheidsverschillen – volgens verschillende maten – negatieve gevolgen hebben voor relaties van gelijkwaardigheid, zodat actie kan worden ondernomen om sociale rechtvaardigheid te herstellen wanneer gezondheidsverschillen hardnekkig blijken.

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B) General research related competences			
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Critical Perspectives in Social Theory	WASS	2016	4
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Orientation on teaching for PhD candidates	Wageningen Graduate School	2016	1
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