Received: 30 September 2020 | Revised: 21 April 2021 | Accepted: 21 May 2021

DOI: 10.1111/bioe.12905

SPECIAL ISSUE: IAB 15TH WORLD CONGRESS

WILEY

How to support equal standing in local health equity?

Beatrijs Haverkamp

Philosophy Group, Wageningen University & Research, Wageningen, The Netherlands

Correspondence
Beatrijs Haverkamp, Philosophy Group, Wageningen University & Research, Hollandseweg 1, 6700 EW, Wageningen, The Netherlands.
Email: beatrijs.haverkamp@wur.nl

Funding information
ZonMw, Grant/Award Number: 854011003

Abstract

Attempts to decrease socioeconomic health disparities face various challenges, which include ethical questions about prioritization and value-conflicts. To deal with these questions in a way that takes equal standing as a central value, this paper explores the potential of a relational egalitarian capability approach to local health equity policies. Especially for local health equity policies, a relational egalitarian capability approach seems promising as it offers more perspectives for action and evaluation additional to considerations of distributive justice. To scrutinize if this approach can offer an adequate normative basis for health equity policies and be a helpful ethical guide in practice, five desiderata are identified that a relational egalitarian capability approach to local health equity should fulfil. These desiderata stem from a consideration of political-ethical pluralism and scarcity of time and resources as non-ideal conditions characterizing public policy practice, as well as of three questions that any capability approach should answer to be applicable in practice. For each of the five desiderata, a brief outline is given of what relational egalitarian theories and the capability approach offer in response to the questions implied by these desiderata. Ultimately, these questions need to be answered in relation to specific policies in particular contexts.

KEYWORDS

capabilities, health equity policy, relational equality

1 | INTRODUCTION

Socioeconomic health disparities are widely considered to be unjust by scholars in public health as well as in theories of justice, despite disagreement about the precise grounds for their injustice.[1] Accordingly, reducing these inequalities via health equity policies has been a common ambition for (local) governments in several high-income countries. This will likely remain so, since the COVID-19 pandemic has exacerbated these inequalities: lower socioeconomic and otherwise disadvantaged groups are more vulnerable to the virus itself as well as to its detrimental economic effects.[2]

[1]Haverkamp, B., Verweij, M. & Stronks, K. (2018). Why socioeconomicinequalities in health threaten relational justice. A proposal for aninstrumental evaluation. *Public Health Ethics*, *11*(3): 311–324; Voigt, K., & Wester, G. (2015). Relational equality and health. *Social Philosophy and Policy*, *32*(2), 204–229; Wilson, J. (2011). Health inequities. In A. Dawson (Ed.), *Public health ethics. Key concepts in policies and practice* (pp. 211–230). Cambridge University Press; Whitehead, M. (1990). *The concepts and principles of equity in health*. World Health Organization. But see Wester, G. (2018). When are health inequalities unfair? *Public Health Ethics*, *11*(3), 346–355.

[2]van Dorn, A., Cooney, R., & Sabin, M. L. (2020). COVID-19 exacerbating inequalities in the US. *The Lancet*, *395*(10232), 1243–1244; Marmot, M. (2020, August 10). Why did England have Europe's worst Covid figures? The answer starts with austerity. *The Guardian*. https://www.theguardian.com/commentisfree/2020/aug/10/england-worst-covid-figures-austerity-inequality

Agreement on the need to reduce health inequalities amongst scholars and policymakers in public health does not mean that realizing health equity[3] comes without challenges. Economically, market mechanisms that regulate, e.g. labour and housing opportunities tend to favour the already wealthy and healthy groups. Politically, health equity aspirations will face disagreement on, e.g. what is reasonable in terms of acting and responsibilities, or on how important health equity is compared to other goals. And when political agreement is reached, health equity policymaking still faces a variety of ethical questions and dilemmas since time and money spent on, e.g. health goals cannot be spent on other goals. For instance, promoting the settlement of fast-food chains in poor neighbourhoods raises questions about weighing the promotion of healthy eating against employment opportunities for people with low education levels. And for reasons of scarcity of time and resources, policymakers in public health will unavoidably face questions regarding the prioritization of groups and neighbourhoods.

To deal with these ethical questions in a way that takes social justice as a central value—as health equity policies aspire to—this paper explores the potential of a relational egalitarian capability approach to local[4] health equity policies. I will thereby assume that both relational egalitarianism and a capability approach are perspectives on social justice of interest in their own right, and thus worthwhile to consider. The central question here is to what extent the combination of relational egalitarianism and a capability approach indeed offers a useful normative framework for local heath equity policy practice.

I will discuss five desiderata that a relational egalitarian capability approach should fulfil in order to be a useful normative guide. For each of the five desiderata, I will sketch what relational egalitarian theories and the capability approach offer. Before doing so, I first briefly clarify why *local* policymaking deserves ethical consideration, and why both the notions of 'capabilities' and of 'relational equality' seem helpful guides especially on the local level.

2 | THE PROMISE OF A RELATIONAL EGALITARIAN CAPABILITY APPROACH FOR LOCAL HEALTH EQUITY

In many countries, a substantial part of the responsibilities for improving public health and diminishing health disparities is placed on regional or local (governmental) institutions.[5] Noteworthy in this regard is the (relatively) recent shift in the UK towards so-called 'localism' meaning that 'responsibilities, freedoms and funding [are] devolved wherever possible'.[6] This resembles the motto of contemporary public health in the Netherlands, characterized as 'decentralization unless'.[7] Of course, there is an enormous variety of ways in which societies organize their efforts to promote population health and in which local, regional and national levels relate[8] that should ultimately be considered, but which cannot be fully discussed here. Relevant for here is that in many countries, it is at the local level that normative questions in health equity are most salient.

Placing responsibility for health equity at the local level seems to be a mixed blessing. Moreover, local authorities will often be best placed to, e.g. develop and implement an intersectoral approach to address the social determinants of health given their tasks in various policy areas, such as housing, transport, social support and health care facilities.[9] Also, they are more likely than national or global institutions to understand the needs of specific disadvantaged groups and how best to address them. The (physical) proximity between local government and citizens makes the former well positioned to know the particular living conditions of groups for which it makes policies.[10]

Moreover, with respect to socioeconomic health inequalities, municipal and regional authorities will often more likely than national governments face constraints on their powers to effectively diminish the socioeconomic inequalities underlying health inequalities. In many countries, local policymakers have overall little power to influence the underlying socioeconomic distribution patterns of socioeconomic health inequalities. That is, they generally have no—or only limited—control over structural mechanisms that produce socioeconomic inequalities like national tax-systems, the formal rules of national education systems, the (inter)national labour market and national systems of social security. While local policymakers generally have *some* influence on people's socioeconomic conditions (e.g. via waste, sewage and property taxes and their eventual remission, and the funding of [extracurricular] programmes at libraries and schools), this may not suffice to counteract the production of structural socioeconomic inequalities. Again, variation per country should be acknowledged in terms of the specific distributive powers local governments have. Relevant for here is that an approach to social justice that looks broader than material distributions may not just

[3]By 'health equity' I refer to 'the absence of systematic disparities in health (…) between social groups who have different (…) positions in a social hierarchy' (Braveman, P., & Gruskin, S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*, *57*, 254–258, p. 254). This definition slightly differs from and is preferable to the circular definition by the WHO, which defines 'inequity' as 'unfair' (see https://www.who.int/topics/health_equity/en/).

[4]By 'local', I refer to policies below national level, thinking primarily of municipalities.

[5]WHO. (2009). *Zagreb Declaration for Healthy Cities. Health and health equity in all policies*. https://www.euro.who.int/__data/assets/pdf_file/0015/101076/E92343.pdf?ua=1

[6]UK Government. (2010). *Healthy lives, healthy people*, p. 8. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

[7]Maarse, H., Jansen, M., Jambroes, M., & Ruwaard, D. (2018). The Netherlands. In B. Rechel, A. Maresso, A. Sagan, C. Hernández-Quevedo, G. Williams, E. Richardson, & E. Nolte (Eds.), *Organization and financing of public health services in Europe: Country reports* (pp. 81–94). WHO, p. 82. https://www.ncbi.nlm.nih.gov/books/NBK507325/pdf/Bookshelf_NBK507325.pdf

[8]Rechel, B., Maresso, A., Sagan, A., Hernández-Quevedo, C., Williams, G., Richardson, E. & Nolte, E. (Eds.), *Organization and financing of public health services in Europe: Country reports* . World Heath Organization. https://www.ncbi.nlm.nih.gov/books/NBK507325/pdf/Bookshelf_NBK507325.pdf

[9]Maarse et al., op.cit. note 7.

[10]Carey, G., Crammond, B., & De Leeuw, E. (2015). Towards health equity: A framework for the application of proportionate universalism. *International Journal for Equity in Health*, *14*, 81, https://doi.org/10.1186/s12939-015-0207-6.

be important in its own right, but could be especially helpful in local policy contexts where distributive powers are limited.

For this reason, I suggest exploring the potential of a relational egalitarian outlook that focuses on improving people's capabilities. By 'relational egalitarianism' I mean those theories of justice that go beyond the so-called 'distributive paradigm'[11] and that understand justice as fundamentally a matter of equal social relations.[12] Relational equality thus entails the ideal of relations of equality in terms of treating one another based on equal standing. Any distributive issues are to be evaluated in the light of this ideal: e.g. do material inequalities stem from, result in or express unequal social relations?[13]

The relational egalitarian concern with equal standing indicates directions for action additional to distributive considerations. As such, it enriches a local policymaker's pallet of actions for justice enhancements. For instance, municipalities may be the first point of contact for persons who apply for social security, and are thereby in the position to treat these applicants as equals, or not; they can physically (co-)shape public spaces in ways that either increase or destroy social cohesion and that facilitate or counteract criminality and violence; they can set up local campaigns against stigmatization or discrimination; and they can effectively contribute to equal political standing by organizing, facilitating or supporting participation regarding local public health issues.

If relational egalitarians are concerned with distribution patterns from the perspective of equal standing, one question to be answered by them is 'the distribution of what?'[14] I propose to consider a capability approach, according to which 'capabilities' rather than material resources, are the ultimate 'things' to be distributed when striving to achieve justice or well-being. Capabilities are the effective opportunities people have to achieve certain beings and doings—so-called 'functionings'—given their personal, material, social and environmental conditions—so-called 'conversion factors'.[15] To clarify what makes an opportunity 'effective', the capability to cycle is illustrative. Only possessing a bike does not imply that one has the effective opportunity to cycle; one also needs the conditions to convert the means of a bike into the end of biking. That is, one needs the mental and physical abilities and skills to ride a bike, and the appropriate social and environmental conditions, such as bike lanes, the legal permission to bike, and not too extreme weather conditions. It is thus the combination of material goods, personal traits, and social and environmental conditions that ultimately *constitutes* the capability to bike.

Likewise, we can think of the capability to be healthy. While local policymakers may not be able to structurally change people's socio-economic conditions, they can still try to influence the conversion factors that ultimately determine people's physical and mental health. That is, by considering the immediate ('downstream'[16]) determinants of health, they can put limits on air pollution in poor neighbourhoods, (co-)shape physical environments in ways that stimulate walking or biking rather than using motor vehicles, they can stimulate healthy eating by encouraging local supermarkets to limit advertising unhealthy food for children. As such, local policymakers can seek to create more equal levels in people's capability to be healthy.

It should be noted that relational egalitarianism and capability approaches need not imply each other, but they can well complement each other. Theoretically, relational egalitarianism needs to take a stance on distributive issues simply because they matter for relations of equality, while capability approaches need normative criteria to specify, e.g. central capabilities and capability levels. Practically, both perspectives deny that material distribution is an end in itself and as such highlight foci of action that align well with the position of those local policymakers concerned with health equity who have limited distributive powers.

3 | FIVE DESIDERATA FOR A RELATIONAL EGALITARIAN CAPABILITY APPROACH TO LOCAL HEALTH EQUITY

So far, the combination of relational egalitarianism with a capability approach seems a promising normative outlook for local health equity policies. But as such, it is still too vague to be applicable to a specific policy practice. To see to what extent this approach indeed provides a proper moral basis for local health equity policies *and* can actually help in dealing with dilemmas and priority setting in practice, it needs further specification.

To this end, I discuss five desiderata that a relational egalitarian capability approach specified for local health equity policy should fulfil. These five desiderata stem from a consideration of (a) two practical challenges to health equity policymaking, as well as of (b) theoretical questions that any capability approach should answer in

[11]Young, I. M. (1990). *Justice and the politics of difference* (pp.15–38). Princeton University Press.

[12]I understand the terms relational equality, democratic equality, and recognitional justice as referring to similar ideals of equal standing, and as de-emphasizing but not denying the relevance of distributive justice. cf. Anderson, E. (1999). What's the point of equality? *Ethics*, *109*(2), 287–337; Fraser, N., & Honneth, A. (2003). *Redistribution or recognition? A political-philosophical exchange*. Verso; Lippert-Rasmussen, K. (2018). *Relational egalitarianism: Living as equals*. Cambridge University Press; Schemmel, C. (2011). Why relational egalitarians should care about distributions. *Social Theory and Practice*, *37*(3), 365–390.

[13]Anderson, E. (2010). The fundamental disagreement between luck egalitarians and relational egalitarians. *Canadian Journal of Philosophy*, *40*, 1–23; Voigt, K. (2017). Too poor to say no? Health Incentives for disadvantaged populations. *Journal of Medical Ethics*, *43*, 162–166;Lippert-Rasmussen, K. Luck egalitarianism. *Ethics*, *127*(4), 939–943.

[14]Sen, A. (1979). Equality of what? The Tanner Lecture on Human Values. Delivered at Stanford University, May 22, 1979.

[15]Sen, A. (1985). Well-being, agency and freedom: The Dewey Lectures 1984. *The Journal of Philosophy*, *82*(4), 169–221.

[16]Epidemiologists sometimes distinguish so-called 'upstream' and 'downstream' determinants of health. Upstream determinants refer to, e.g. ethnic segregation or the distribution of income and education levels, i.e. 'the causes of health inequalities that reflect the social structure' (Asada, Y. (2007). *Health inequality: Morality and measurement*. University of Toronto Press, p. 14). Downstream determinants refer to the material, behavioural and psychosocial factors that (almost) immediately cause health problems, such as air pollution, poor housing, a lack of social support, smoking and stress. Considering the diversity of these downstream determinants, we can see that the degree to which a low income or a low education level correlates with ill health ultimately depends on how strongly income and education levels actually lead to factors that harm people's health.

order to be applicable in practice. That is, practically, public policymaking takes place in a context of political pluralism and thus faces a variety of moral positions and intuitions regarding health inequalities. And, second, public policy practice is characterized by scarcity of both time and resources. Theoretically, applying a capability approach to a practice comes with a series of questions that must be decided upon by considering the specific practice.[17] Here, three of these questions will be considered as most relevant. Namely, *which specific capabilities* should be central, whether *a focus on capabilities or functionings* is appropriate, and how to *weigh different capabilities*.

Taken together, these practical and theoretical considerations help to formulate five desiderata for a relational egalitarian capability approach to local health equity. That is, the approach (a) offers one or more relatively uncontroversial justifications for health equity policies to address political pluralism; (b) helps to identify injustices in relation to health, and their relative degrees to guide priority-setting under conditions of scarcity; (c) tells us which capabilities should be central in health equity policymaking and implementation to bring policy-focus in a context of scarcity; (d) tells us when the complex and layered notion of 'capability' should be focused upon, and when a focus on the simpler notion of 'functionings' may suffice—again—to deal with scarcity; and (e) tells us how to weigh different capabilities to cope with dilemmas that stem from in practice competing capabilities. For each of these five desiderata, I sketch what the traditions of both relational egalitarianism and the capability approach offer in response to the questions implied by these desiderata.

3.1 | Justifying health equity policies

To provide a normatively sound and broadly acceptable basis for public policies in the light of political pluralism, the approach should offer justifications for seeking health equity that are compelling to citizens, politicians and policymakers with various moral points of view.

Existing relational egalitarian approaches deliver (at least) three types of justifications for health equity policies based on deontic, instrumental, and expressivist considerations. By 'deontic', I refer to the idea that there is a duty to reduce inequalities that do not accord with principles of justice that are interpersonally justifiable. Principles are interpersonally justifiable if all members of a political community can agree to them while understanding themselves as free and being of equal moral worth.[18] By 'instrumental', I mean the consideration that (more) equal levels of goods or capabilities importantly contribute to a situation in which people treat one another as beings of equal standing. 'Expressivist' refers to the idea that policies and interventions may have an expressive dimension and can as such express equal respect to members of a political community. These three considerations may not be exhaustive for relational egalitarians but qualify as typical relational egalitarian considerations in the sense that they take equal moral standing as the ultimate goal in, e.g. policymaking.

Applied to health equity policies, the deontic test for equal standing entails questioning whether existing health inequalities are in accordance with principles of justice that are interpersonally justifiable. In this contractarian spirit, Norman Daniels has notably argued that if the socioeconomic inequalities underlying health inequalities do not accord with (a slightly adjusted version of) John Rawls's mutually justifiable principles of justice as fairness, the associated inequalities in health are unjust.[19] Although this might be a point of dispute, many would agree that most socioeconomic inequalities in contemporary capitalist democracies *do not* accord with Rawlsian principles of justice given, e.g. the strong influence of (hereditary) economic capital on economic opportunities. And so, existing socioeconomic health inequalities within these countries are unjust and come with a duty to ameliorate them.[20]

Second, there are instrumental reasons to object to systematic health inequalities if they lead to oppressive relationships by creating inequalities in power and status. As argued elsewhere, socioeconomic health disparities can result in relational injustices, such as in unequal risks of marginalization and of stigmatization.[21] And so, by taking (relatively) equal health levels as a means to achieve the end of relations of equality, relational egalitarians do have instrumental reasons to support health equity policies.

Third, public attempts to minimize inequalities in health can be taken as a way of expressing equal respect or equal concern, and the absence of these attempts as a failure to do so. For instance, providing universal medical care can be understood as a matter of recognizing each person's moral worth.[22] Considering the social determinants of health and disease, the question arises as to what extent policies for disease prevention and health promotion have an expressive dimension too. Kristin Voigt shows how public policies and legislation can have an expressive dimension in four ways that can be relevant for public health equity policies too.[23] She mentions communicating 'equal membership' of the community, expressing 'respect [for] decision-making capacities', 'giving equal weight to equally important interests', and 'acknowledging background injustice'.[24] To what extent they apply to health equity policies ultimately depends on the particular policy, and—as Voigt argues—*potentially* also on the intentions and/or actual attitudes behind these policies.

All these considerations deserve further elaboration and may raise many more questions than I can address here, but it seems clear

[17]Robeyns, I. (2017). *Wellbeing, freedom and social justice: The capability approach re-examined*. Open Book Publishers.

[18]Anderson, op. cit. note 13.

[19]Daniels, N. (2008). *Just health. Meeting health needs fairly*. Cambridge University Press.

[20]One may object that since Rawls's theory is ideal theory, no society will ever meet its demands, and that its principles are therefore inapt to use as criteria of interpersonal justification.

[21]Haverkamp *et al.*, op.cit. note 1.

[22]Anderson, op. cit. note 12, pp. 330–331; Voigt & Wester, op. cit. note 1.

[23]Voigt, K. (2018). Relational equality and the expressive dimension of state policy. *Social Theory and Practice*, *44*(3), 437–467.

[24]Ibid: 460–463.

that the ideal of relational equality provides deontic, instrumental, and expressivist justifications for health equity policies. While they will not convince wholehearted libertarians, these justifications could cater for different moral 'styles' as they appeal to different types of ethical reasoning.

3.2 | Identifying injustice

To provide guidance in health equity policy practice characterized by scarcity, the approach should help to identify injustices and degrees of injustice in health, such that policy priorities can be set. The above discussed relational egalitarian rationales for seeking health equity provide three perspectives for analysing health inequalities and public health policies. Namely, the deontic rationale supports analysing which health inequalities are or stem from interpersonally unjustifiable inequalities, while the instrumental rationale supports analysing which health inequalities result in social and/or economic injustices.[25] In addition, considering the expressivist rationale, non-distributive injustices in public health policies can be identified by analysing the expressive dimension of health policies. Following Voigt, attention should be paid to the communication of unequal membership of the community (e.g. via stigmatization), expressions of disrespect for decision-making capacities (e.g. via unjustified paternalism), unequal considerations of equally important interests (e.g. via unequal opportunities for political participation in public health), and the misrecognition of background injustice (e.g. via absence of financial support).[26]

A further question for priority setting to address is how to discern degrees of injustice. A capability approach leads us to distinguishing degrees of capability-achievements. Several capability scholars have argued that justice requires only minimal capability levels such that priority is to be given to those who fall below a certain threshold. Determining that threshold by the ideal of relational equality, Anderson argues that justice requires that people have sufficient capability levels to function as equals, and to avoid oppressive relationships.[27] What counts as being sufficiently healthy for equal standing or functioning as an equal, depends of course on the context under consideration.

However, such a 'sufficientarian' approach can only be a first step, as for those groups who fall below the level, the question of priority setting remains.[28] In this regard, Daniels & Sabin's notion of accountability for reasonableness (A4R) could be applied to set priorities in public health policy. This approach to priority setting would need adjustments though. If relational equality demands that outcomes are interpersonally justifiable, more should be said about the question of what reasons are acceptable within that justification process—answers to which likely depend on the political and historical context.[29]

The three relational egalitarian justifications for health equity policies thus seem to provide guidance in identifying injustices in relation to health. To distinguish degrees of injustices, we can translate injustices into degrees of capability-achievements. The potential of an (adjusted version of) an A4R-approach deserves further exploration for the issue of priority setting in health equity policies.

3.3 | Selecting capabilities

A further desideratum, and one that comes with any capability approach, is that it specifies which capabilities should be central to, in this case, health equity policies. This is important to the extent that policymaking and implementation is—due to scarcity of time and resources—helped by focusing on specific capabilities, rather than being concerned with *all* capabilities that are relevant for relational equality.

According to Anderson's relational egalitarian capability approach people are entitled to 'whatever capabilities are necessary to enable them to avoid or escape entanglement in oppressive relationships' and to 'the capabilities necessary for functioning as an equal citizen in a democratic state'.[30] Although Anderson does not mention the capability to be healthy as a distinct capability, both physical and mental health importantly contribute to capabilities needed to function as an equal. For instance, being in good mental and physical health is generally crucial to have and keep a job, which supports equal standing in the labour market.

For health equity policies, the capability to be healthy seems the self-evident focus. But 'being healthy' is an all-encompassing and quite indeterminate idea that—taken as the central capability—would give little guidance in practice. Depending on how 'health' is defined, it might even be at odds with the idea of a 'capability' as this presupposes that being healthy is something one chooses to be.[31] Considering local health equity policy practices, their aim is better understood as promoting those capabilities that can be derived from knowledge of the (local) social determinants of health. That is, policymakers and officers in public health seek health equity, generally

[25]Both these types of injustices may be of a primarily distributive nature (economic inequalities) but need not be so: e.g. stigmatization can both be a determinant and a result of health problems. cf. Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American Journal of Public Health*, *103*(5), 813–821.

[26]Voigt, op. cit. note 23.

[27]Anderson, op. cit. note 11; Anderson, E. (2010). Justifying the capabilities approach to justice. In H. Brighouse & I. Robeyns (Eds.), *Measuring justice: Primary goods and capabilities* (pp. 81–99). Cambridge University Press.

[28]cf. Fleck, L. M. (2016) Just caring. In A. Rid & C. Fourie (Eds.), *What is enough? Sufficiency, health, and justice* (pp. 223–243). Oxford University Press.

[29]cf. Daniels, N. & Sabin, J.E. (2008). Accountability for Reasonableness: an update. *BMJ*, *337*, doi:10.1136/bmj.a1850;Badano, G. (2018). If you're a Rawlsian, how come you're so close to utilitarianism and intuitionism? A critique of Daniels's accountability for reasonableness. *Health Care Analysis*, *26*(1), 1–16. Hasman, A., & Holm, S. (2005). Accountability for reasonableness: Opening the black box of process. *Health Care Analysis*, *13*(4), 261–273.

[30]Anderson, op. cit. note 12, p. 316.

[31]Tengland, P. A. (2016). Venkatapuram's capability theory of health. A critical discussion. *Bioethics*, *30*(1), 8–18. But see Ram-Tiktin, E. (2011). A decent minimum for everyone as a sufficiency of basic human functional capabilities. *American Journal of Bioethics*, *11*(7), 24–25; Venkatapram, S. (2011). *Health justice*. Polity Press.

by influencing behaviours (physical movement, consumption) and living conditions (housing, social environment) that are known to cause health problems among the least healthy groups. From a capability perspective, these 'sub-goals' can be seen as capabilities in their own right, such as the capability to eat healthily, or the capability to live in a safe environment.[32]

So, whereas more equal levels in the capability to be healthy is the ultimate aim of health equity policies, their sub-goals are better understood as promoting the various capabilities that contribute to health. The question of which capabilities should be central to local health equity policies, is thus to be answered on the basis of knowledge about the local social determinants of health.

3.4 | Capabilities or functionings

In a context of scarcity, it is helpful if a capability approach to health equity clarifies when a focus on the complex notion of capabilities is appropriate, and when a focus on functionings is justifiable. Measuring and monitoring capabilities is notoriously laborious as capabilities are conceptualized as the combination of personal traits and abilities, as well as of social, material and environmental circumstances. Some have taken this complexity of capabilities as a reason to dismiss the concept altogether, arguing that capabilities do not offer 'a *public* and readily *quantifiable* measure for interpersonal comparisons'.[33]

Interpersonal comparisons are crucial in health equity policies, as they help to set priorities by measuring existing inequalities as well as to evaluate policies by measuring their effects. In policy practice, interpersonal comparison is generally only feasible via group comparisons by 'public' and 'readily quantifiable' indicators, such as 'having diabetes', 'income' or 'having work'. Such measures indicate functioning levels from which we can derive what capability levels people *must have had* to achieve that functioning. However, they cannot indicate the capability levels people actually *have* for functionings that are not-yet achieved (or will never be achieved, in cases people don't want to). For simple indicators used in group comparisons do not capture the specificities of individual situations that make or break people's capabilities. And so, policymakers concerned with measuring are forced to focus on functionings—i.e. achieved doings and beings that are measurable by single indicators.[34]

This is not necessarily a compromise. First, functionings *can* serve as an indication of capabilities to the extent that the outcome measured can be safely assumed to be a doing or being that (almost) everyone seeks to achieve, such as 'being free from pain or disease', 'feeling satisfied' or 'feeling happy'. In these cases, measuring how many people actually feel satisfied rather than measuring (suppose this is possible) how many people have the effective opportunity to feel satisfied likely comes down to the same number: if people *can* achieve it, they will. Second, regarding functionings that are unlikely to be universally aspired to, such as 'being politically active', observed inequalities in functionings provide a reason to conduct further qualitative research into actual capability levels. Such research should map the presence of material goods, personal traits, and social and environmental conditions that constitute the capability under scrutiny. Third, group comparisons in terms of functionings are an important first step to identify structural injustice by identifying combinations or clusters of disadvantages, such as health problems and homelessness. A subsequent step would be to link these disadvantages to underlying structural injustice.[35] So, to measure inequalities and policy effects, and to identify structural injustices, functionings seem a justifiable focus for health equity policies, given that measuring capability levels is time-consuming.

Apart from measuring inequalities and policy-effects, policy-making is concerned with the formulation of policy-goals. In this regard, a relational egalitarian approach prefers a focus on capabilities rather than functionings, as the former implies respecting citizens as autonomous agents. Contrarily to that, functioning-focused policies may tend to let effectivity prevail over individual freedom by, e.g. prohibitions or coercive policies to ensure that functionings are achieved. Doing so may be defended by arguing that the aspired outcome is in the best interest of persons, and/or by denying that individual responsibility should be given any weight.

Considering individual responsibility, relational egalitarians typically distinguish themselves from luck egalitarians for whom individual responsibility is a central criterion of justice.[36] Instead, relational egalitarians are primarily concerned with the question of how citizens treat each other and how a state treats its citizens due to which they tend to see individual responsibility as less relevant than collective (or 'political') responsibility.[37] At the same time, given the importance of interpersonal justification, it is key for relational equality to treat people not as victims of their circumstances but as actors that can be held accountable for their actions. The idea of collective responsibility does not deny individual responsibility but assumes that we all—to different degrees—partake in reproducing social structures that, e.g. result in health inequalities. From that perspective, a recurring question for health equity policies is what can be reasonably expected from individuals with regard to caring for their own health. How that question is answered indicates whether a focus on functionings may replace a focus on capabilities: if (full) individual responsibility for health is deemed unreasonable to expect,

[32]Indeed, 'health equity policies' are not (necessarily) restricted to public health departments or public health officers. This is why the WHO advocates intersectoral approaches under the header of 'Health in all Policies' or 'Health *Equity* in all Policies' (e.g. WHO, op. cit. note 5; WHO. (2014). *Health in All Policies (HiAP) Framework for Country Action*. https://www.who.int/healthpromotion/hiapframework.pdf

[33]Kelly, E. (2010). Equal opportunity, unequal capability. In H. Brighouse & I. Robeyns (Eds.), *Measuring justice: Primary goods and capabilities* (pp. 61–80). Cambridge University Press, p. 62 (emphasis mine).

[34]Note that qualitative research into, e.g. living conditions and health experiences in specific neighbourhoods can come close to measuring capability-levels.

[35]Young, I. M. (2001). Equality of whom? *The Journal of Political Philosophy, 9*(1), 1–18.

[36]e.g. Anderson, op. cit. note 13; Lippert-Rasmussen, op. cit. note 12.

[37]Young, I. M. (2003). Political responsibility and structural injustice. The Lindley Lecture. Delivered at the University of Kansas, May 5, 2003.

functionings are a justified policy-focus. If it is reasonable to expect a considerable degree of responsibility, policy-goals should be formulated in terms of capabilities.

Considering paternalism, this is problematic for relational egalitarians because of the disrespect for decision-making capacities that is (presumably) implied by paternalistic acts. Voigt argues that paternalism can violate relational equality, because it assumes an 'asymmetry of knowledge and competency between the agents involved.'[38] Of course, the question is what 'competent adults' are: if the lack of competence that forms the basis of a paternalistic act is *universal*, speaking of an asymmetry of competency between agents seems mistaken.[39] For instance, if we can assume that all people—including politicians and policymakers—are equally vulnerable to nicotine addiction, and thus equally poor in autonomous decision-making in relation to smoking, this would support a general ban on cigarettes. This calls for distinguishing universal from targeted paternalistic policies.[40] 'Functionings' could thus be a justifiable focus for universal policies that have no particular target-group, whereas targeted-policies should focus on capabilities to preserve respect for the decision-making capacities of the group concerned.

All in all, for measuring inequalities and policy-effects, functionings seem a justifiable focus given the complexity of measuring capability levels. When formulating aims of health equity policies, the focus should be on capabilities in order to respect people's agency, unless (a) it is unreasonable to expect full individual responsibility for health, or (b) policies do not aim at particular target-groups.

3.5 | Weighing capabilities

To offer guidance on ethical dilemmas that arise in health equity policies due to either scarcity or value pluralism, a last requirement is that the approach tells us how to weigh different and in practice competing capabilities. For example, the capability to be healthy and the capability to have good education can be at odds: providing information on living healthily at secondary vocational schools addresses a relevant group in the light of health equity. But as these schools often cope with problems such as criminality and early dropouts, spending time on health-lessons may not be seen as a priority.

There are at least two ways to ascribe weights to different capabilities: by democratic decision-making processes and by identifying one 'master-value' in light of which to weigh different capabilities.[41] Since relational equality honours equal standing in political decision-making, democratic decision-making seems the preferable approach for coping with dilemmas in health equity policies, and one that can work especially well at the local level of communities and neighbourhoods. This approach raises the question of what makes decision-making 'democratic': does that require direct political participation or does a representative system suffice? That is, should the weighing of options be pursued by the citizens subjected to the particular policies or by political representatives? The idea of 'participatory parity' as a demand of social justice in public health implies the 'obligation to engage communities and groups in discussion and deliberation about the goals of public health research and policy and to involve them in the work itself',[42] and thus pleads for direct democracy.

However, in policy practice, directly involving communities in decision-making processes or public deliberation is easily perceived as too demanding for public health professionals, as it is, e.g. too time-consuming. Another reason to refrain from participatory processes in public health policies is that psychosocial or health problems suffered by the target-group renders political participation too demanding for the group concerned. To what extent objections like these justify a reluctance to direct democratic decision-making and/or deliberation, requires a much more elaborate discussion than I can offer here. Nevertheless, it is good to note that if there are good reasons to dismiss *direct* participatory processes, *indirect* democratic decision-making procedures could still address recognition-related concerns. For instance, Anderson argues that a representational system can suffice for democratic equality provided that politicians and policymakers are 'systematically responsive to the interests and concerns of people from all walks of life. (...) [requiring] (i) awareness of the interests and problems of people from all sectors and (ii) a disposition to serve those interests.'[43] It is in this regard that concerns of recognitional justice could be met: representational democratic decision-making is then to be informed by existing studies upon, e.g. views and value-patterns typical to the groups subjected to the policies under discussion.

Another, non-procedural approach to the question of weighing capabilities in decision-making is to take the aim of relational equality as a 'master-value' such that the greatest weight is given to the capability that serves 'equal standing' or 'functioning as an equal' best. This could imply considering policy-effects: in the case of competing capabilities, an analysis is to be made of how the different policy options can be expected to affect a person's functioning as an equal. The challenge for this weighing method is that decision-makers have to predict the effects of policy decisions on capabilities. Of course, such predictions about policy-effects come with great uncertainties if only because policies and interventions generally work in indirect ways and are just one among many factors that determine equal standing, e.g. promoting healthy living among pupils ideally contributes to better learning opportunities via better concentration, but this effect depends on many more factors in the social environment of young adults. And to what extent an improvement of learning opportunities fosters equal standing in the system of labour ultimately depends on other mechanisms in the labour market. But while such

[38]Voigt, op. cit. note 23, pp. 461–462.

[39]Conly, S. (2013). *Against autonomy. Justifying coercive paternalism*. Cambridge University Press.

[40]Carey et al., op. cit. note 10.

[41]Robeyns, op. cit. note 17, pp. 71–72.

[42]Blacksher, E. (2012). Redistribution and recognition. Pursuing social justice in public health. *Cambridge Quarterly of Healthcare Ethics*, *21*, 320–331, p. 328.

[43]Anderson, E. (2007). Fair opportunity in education: A democratic equality perspective. *Ethics*, *117*(4), 595–622, p. 596.

analyses will not provide univocal guidance for decision-makers, that does not mean that there is no point at all in trying to foresee what the *likely* effects of policies on capabilities will be.

Apart from predicting effects on capabilities, equal standing can be taken as a master-value by scrutinizing the expressive dimensions of the policy options at stake. The four ways in which policies can fail or succeed to express equal standing as identified by Voigt (2018) can be helpful for such examination. Just as with predicting policy effects, it is questionable that this weighing method provides clear implications for decision-making. For example, the choice for education on healthy living as well as for intensifying educational surveillance to decrease dropout levels are paternalistic and thus likely fail to 'respect decision-making capacities' of pupils. But that does not mean that both forms of paternalism are problematic, considering the age of the group addressed. Positively, both choices may entail an 'acknowledgement of background injustice' either via, e.g. acknowledging prevalent unhealthy habits in the social environment of the pupils, or via, e.g. acknowledging the criminal environment that pulls adolescents away from school or undermines their motivation to finish school. Moreover, there is another question of how to weigh options in the hypothetical case that a policy expresses equal standing, while having a negative effect on capability levels.

All in all, a relational egalitarian capability approach provides at least two methods to weigh competing capabilities. But neither of them unequivocally tells us what to decide in the face of dilemmas. It ultimately depends on the practical context if direct or indirect democratic decision-making is to be preferred. And taking 'equal standing' as a master-value may not have any clear implications for decision-making, although it can help policymakers to explicate the implications of different policy options and thus foster as well as possible people's equal standing.

4 | DISCUSSION AND CONCLUSION

A relational egalitarian capability approach to local health equity policies seems promising to the extent that it offers non-distributive considerations and directions of action for policymakers with limited distributive powers. To see if it is a helpful ethical guide in policy-practice, I have explored if it can satisfy five desiderata that a relational egalitarian capability approach to local health equity should fulfil. This list of desiderata may not be exhaustive: each specific context may face additional challenges that bring additional requirements. For instance, in non-English speaking countries, the central concepts of the approach must be translated into a terminology that is understandable by the practitioners working on health equity. But even in contexts where English is the dominant language, scholars working with the capability approach have pointed out that its terminology may need simplification or adjustment for practical use.[44]

[44]Javornik, J., Yerkes, M. A., & Jansen, E. (2019). From the capability approach to capability-based social policy. In M. A. Yerkes, J. Yavornik, & A. Kurowska (Eds.), *Social policy and the capability approach. Concepts, measurements and application* (pp. 107–124). Bristol University Press.

Based on the work by relational egalitarians and capability scholars, I have formulated preliminary responses to the questions implied by the five desiderata. They show that a relational egalitarian capability approach offers (a) three rationales for justifying health equity policies; (b) three corresponding ways to identify injustices in health; (c) a way to select central capabilities for health equity; (d) several justifications for a focus on functionings rather than capabilities; (e) two justifiable methods for weighing capabilities, which as such do not provide unequivocal answers.

In other words, the here discussed considerations of a relational egalitarian capability approach can provide normative guidance to local health equity practice regarding justifying policies (desiderata a and d) and priority setting (desiderata b and c). Regarding weighing dilemmas (desideratum e), it will not offer unambiguous solutions. Still, the approach does indicate two justifiable methods for solving dilemmas, and with the second—taking equal standing as a master value—we have to weigh the importance of (equal levels of) a capability. Regarding health, this will in some cases point to the fundamental importance of equality in health for functioning as an equal. In other cases, it will help to reveal the ethical limits to health promotion, given its negative implications for equal standing. As such, the approach can help those working on health equity at the local level with how to support relations of equality and the public recognition of equal standing.

ACKNOWLEDGEMENTS

The author thanks Marcel Verweij and the two reviewers of *Bioethics* for helpful comments on earlier drafts. She thanks the employees of the Public Health Department of the Municipality of Utrecht (NL) for giving her insight into their daily work on health equity. This research was funded by ZonMw (854011003).

CONFLICT OF INTEREST

The author declares no conflict of interest.

ORCID

Beatrijs Haverkamp https://orcid.org/0000-0001-5550-4802

AUTHOR BIOGRAPHY

Beatrijs Haverkamp is a postdoc researcher at the Philosophy Group of Wageningen University. She completed her PhD in 2019 on conceptual and normative questions regarding socio-economic health inequalities. In her present project, she investigates ethical questions in the practice of local policymaking for health equity.

How to cite this article: Haverkamp B. How to support equal standing in local health equity? *Bioethics*. 2021;00:1–8. https://doi.org/10.1111/bioe.12905