Class, Health, and Justice

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> If living were something that money could buy,
> Then the rich would live, and the poor would die.
> (Black spiritual, United States)

PERHAPS THE RICH DON'T BUY HEALTH, BUT THE outpouring of research documenting class inequalities in health demonstrates that they *do* live longer, and the poor *do* die, in greater numbers at all ages; and the poor are sicker, too (Wilkinson 1996; Kaplan and Lynch 1997). Socioeconomic inequalities in health persist even in the wealthiest countries; they hold true for both treatable and untreatable diseases, and for injuries; and they persist even when differences in risk-taking behavior are taken into account.

Such inequalities in health strike many of us as deeply unjust. But what, precisely, is unjust about them? One's initial response is likely to be that these inequalities demonstrate the need for universal access to health care, and that class inequalities in health must be the result of differences in access to health care services, or in the quality of services received. This body of research shows, however, that class inequalities persist even in countries with universal access to care, where health care resources seem to be distributed justly. The just allocation of health care

The Milbank Quarterly, Vol. 76, No. 3, 1998

resources is a challenging task, but class inequalities in health raise broader issues.

A second attempt to locate the injustice in class inequalities in health might find them in the impoverishment of the lowest classes. Surely all but the very poorest countries can avoid exposing a sizable proportion of their populations to avoidable, material deprivation that denies them even a minimally decent standard of living. Insofar as the greater burden of disease associated with lower socioeconomic status is a consequence of material deprivations of this scale, it is unjust. We need no elaborate theory of justice to show that an affluent society's citizens are entitled to have their basic needs met.

This response, however, misses the point of much of the research on the bearing of class on health, which has shown that it is not only the poor whose health suffers as a result of socioeconomic inequality. In rich countries, those at the bottom of the scale may suffer greatly, even though their absolute income is greater than that of the middle classes in less wealthy countries, who may enjoy greater health. Moreover, the richest, even in wealthy countries, enjoy better health and longer life than those in the next position down, even though both income strata are well-to-do by any standard. If class inequalities in health are unjust, these differences also signal a problem of justice quite apart from poverty itself.

The literature on class inequalities in health focuses our attention on a population's *distribution* of health and on the inequalities themselves, whether or not these are linked to poor health care or to poor living standards, the traditional foci of ethical concerns.

We begin with a discussion of the lack of attention to class inequalities in health within the literature of distributive justice. We identify two sources for this neglect: One is a preoccupation with the distribution of health *care* as opposed to the distribution of health. The second is the belief that a concern with class inequalities in health is misplaced because the actual source of injustice is inequality in income and wealth. In this view, the distribution of health may reflect the justice or injustice of the underlying distribution of income and wealth, but it is not an injustice on its own. We defend the thesis that the inequalities in health raise issues of justice independent of both the allocation of health care resources and the general distribution of income and wealth.

In the central section of the paper, we offer four alternative accounts of justice or equity and health. These are not accounts of general theories

of justice but, rather, pertain directly to the distribution of health. Only the second of these accounts identifies class inequalities in health as intrinsically unjust. Each of the other three accounts locates the moral problem elsewhere.

We believe each of the four accounts has some plausibility; we mean to open the argument rather than settle it. Questions about the justice of class inequalities in health are ideally answered in the context of a well-formulated general theory of distributive justice. No consensus exists on such a theory, and it is beyond the scope of this article to propose one. Our more modest goal is to place the issue of the nature of the injustice in class inequalities in health in the context of contemporary theories of justice. Our inquiry may also help us to determine when differences over strategies for ameliorating these social inequalities in health stem from differing moral assumptions rather than from disagreements over effectiveness or cost.

For purposes of this discussion, we use the terms "class," "socioeconomic group," and "social stratum" more or less interchangeably. We leave for another occasion the question of whether and how our analysis would be affected by the choice among these social categories.

We close with notes on two further, related topics: first, the implications of the hypothesis that the degree of income inequality in a society affects that society's health, and, second, the problems that personal responsibility for health may bring to any account of justice regarding inequalities in health status.

Health versus Health Care

Nearly everything philosophers have written on justice and health is confined to issues of the allocation of health *care*. Yet social inequalities in health persist even when health care resources are more equitably distributed. Why, then, have these inequalities not been considered as an issue of distributive justice?

Perhaps some contributors to this literature are simply unaware of important determinants of health, once basic needs have been met, other than biology and health care, leading them to equate the obligation to improve a population's health with the obligation to expand its access to health care. At the same time, there is a growing recognition that some health care may well be too expensive and offer too little benefit to

justify inclusion among society's obligations. This is the familiar problem of the "bottomless pit," endlessly swallowing attempts to satisfy all health care needs.

Consider the problem of the bottomless pit as it appears in Kenneth Arrow's (1973) early review of Rawls's *A Theory of Justice* (Rawls 1971). Arrow suggests that "maximin" principles of distributive justice (of which Rawls's principles of justice are an example) cannot escape the problem of the bottomless pit of health care needs. Maximin principles of justice direct us to distribute resources in such a way that the worst position in society (the "minimum" position) is made as well off as possible (the "minimum" position should be "maximized"). Maximin principles are implausible, Arrow argued, when we consider individuals with expensive health care needs as among the occupants of the minimum position. Those with expensive health care needs might require nearly unlimited health care resources, draining the economy and yielding relatively little benefit. Can justice, Arrow asked, plausibly require huge sacrifices of everyone but the worst-off, in order to realize what may be very small benefits for that group?

For many, Arrow's argument suffices to show that we must avoid the notion that we owe people *health.* They conclude that, at most, we owe some fair proportion of health care resources, or perhaps that we have no specific health-related obligations at all. This conclusion, however, does not follow from Arrow's argument. For even if we must exempt expensive health care from maximin principles of justice (to avoid "social hijacking" by expensive needs), we may still be obligated to adopt other social policies—for example, a narrowing of income inequality—under which those in the worst-off position are as well off (and as healthy) as possible.

Other explanations for the focus on health care, rather than health, stem from aspects of the theories of equity or justice themselves and not just their empirical assumptions. In the wake of Rawls's work, philosophers have increasingly turned away from theories of "welfarism" (Dworkin 1981a; Arneson 1989; Cohen 1989). Welfarism is the doctrine that justice (or, for some theorists, morality as a whole) consists in some distribution or other of welfare or "well-being." It states that what matters in questions of morality or justice can only be individuals' welfare. Rejecting welfarism, Rawls proposed that justice is concerned with what he termed "social, primary, goods," such as opportunities, income, and wealth, and not welfare.

One effect of Rawls's influence has been the development of alternatives to welfarism in the form of "resourcist" theories of justice that—as with Rawls's social, primary goods—eschew interpersonal comparisons of welfare in favor of interpersonal comparisons of resources (an exception is Sen's "capabilities," which occupies a zone between resources and welfare (Sen 1980). This shift from welfare to resources can also be described as a shift from outcomes to means; rather than asking what a given bundle of resources can "do" for a person (Sen 1993), or what outcomes he can achieve with it, we ask whether his resource holdings are fair relative to what others have. The claim made by resourcists is that what is fair can be determined without appealing to the concept of welfare.

Health is more easily assimilated to the notion of welfare or outcomes than it is to the notion of means or resources. It is impossible to say, according to resourcist theories, that a particular distribution of health (or of welfare generally) in a given society is just or unjust. From a resourcist perspective, whatever pattern of welfare or health is produced in society by a particular distribution of resources is just, so long as resources are distributed justly.

If these considerations explain why the distribution of health has been ignored in the literature of distributive justice, they do not justify this omission. The factual assumption we mentioned—that health is primarily a function of one's individual biology and of the quality and extent of health care services one receives—is clearly mistaken. For example, health may be affected by the degree of income inequality in a given society, and social policy can usefully address this basic social question. As we come to learn more about the mechanisms by which inequality affects health, other effective social and economic measures may be identified. Arrow's argument about the "bottomless pit" of needy patients does not necessarily have the same force when applied to determinants of health other than expensive, largely futile, acute health care interventions. We discuss other implications of resourcist theories of distributive justice in the next section.

Is Health Special?

The intuition that it is morally objectionable when people in different income strata have different average life expectancies and health statuses

seems to be a fairly robust one. This intuition may not extend to other inequalities, in particular to the fact of income strata themselves and resulting class differences in the standard of living. Health, unlike income and unlike other goods and services, seems special to many of us, in that the case for its equal distribution seems more compelling.

Philosophers and others differ on whether this intuition is rationally defensible. Some egalitarian theories of justice, whether welfarist or resourcist, defend a view diametrically opposed to this intuition. They maintain that justice requires equalizing income and wealth or welfare but that this kind of "global" equality is consistent with inequalities in specific goods, including health. Ronald Dworkin (1981b), a leading egalitarian resourcist theorist, for example, proposes that justice consists in people having the same amount of resources with which to purchase health insurance (he does not discuss other determinants of health); it does not consist in equal health. According to Dworkin, people with equal resources must be allowed to budget their resources as they wish, in light of their differing goals and life plans. Some people will prefer a life of security and purchase as much coverage as they can, leaving little for other things, whereas others will prefer to spend that money on the goods and services they believe will enhance their lives, and so will purchase "bare-bones" coverage.

Although Dworkin's resource egalitarianism is obviously remote from real world inequalities, it illustrates why some believe that there is no "just" distribution of health. We might be tempted to conclude from a theory like Dworkin's that in the real world, where income and wealth are vastly unequal, the basis for our intuition that socioeconomic inequalities in health are unjust is that the inequalities in income and wealth are unjust. We must decide, however, whether it is income inequalities or health inequalities that condemn the other. Perhaps existing inequalities in income and other resources are unjust in part because they produce inequalities in health. For Dworkin, justice requires equalizing income and wealth, irrespective of any consequences for health. If health inequalities are morally wrong sui generis, however, then this may provide a reason for equalizing income and wealth.

In support of the intuition that health is special, and that there can be just or unjust distributions of health, are views that defend different criteria or principles of distribution for various goods (Walzer 1983). Some of these views oppose income inequalities and some do not, but

they all maintain that health, as opposed to income and wealth, is regulated by a separate principle of justice (Culyer 1993; Culyer and Wagstaff 1993). One view of this sort is a "specific egalitarianism" that seeks equality in each important good (Tobin 1970). Another approach is to argue that health raises considerations of justice that require its "insulation" from the sphere of the market. Norman Daniels (1985) has argued that health is a requisite of equal opportunity, and thus that health care, like education, should be earmarked for more equal distribution, rather than distributed according to ability and willingness to pay. This is true, according to Daniels, even if individuals' share of society's resources is fair in other respects.

In what follows we present four accounts of equity and health, each presupposing that a society's distribution of health can be prima facia just or unjust. In other words, they presuppose that (1) justice does bear on the issue of a society's distribution of health and that we can formulate goals of an equitable health policy on that basis; but that (2) justice in the sphere of health policy is not justice, all things considered. Only a general theory of distributive justice that addresses the basic social and economic structure of a society can tell us how to balance and weight the various demands of justice, or what to do in cases where they conflict. We do discuss some points of contact between general principles of justice and principles that apply to the domain of health. Although the four accounts of equity and health do treat health as special, we acknowledge that whatever justice demands in that sphere is only provisional and subject to its broader requirements.

Equity and Health: Four Alternative Views

In the literature documenting the pervasive class differences in health, two goals of health policy are often mentioned: first, that society should seek to maximize the sum total of health of its members, and, second, that society should pursue a policy of equal health between classes. We discuss these two views first. The third and fourth views, also discussed below, revisit "maximin" principles of justice, but they define the minimum position in alternative ways. Importantly, only the second view—that we should attempt to equalize health between classes—reflects the idea that class inequalities in health are intrinsically unjust.

Equity as Maximization

According to the first view, the troubling aspect of richer people's generally longer life span and, on average, healthier lives is the indication that the higher morbidity and mortality of the less well off might be avoidable. Given reasonable assumptions, the better health enjoyed by the upper classes is evidence that the lower classes could also enjoy better health. Data on class differences in health reveal the extent of premature deaths and excess morbidity. What is troubling is that such a "society is less healthy than it could be"; the total sum of health of its members is lower than we might achieve with the right policies in place.

This notion that health policy should aim to produce as much health as possible for a given population seems to be regarded in some quarters as self-evident. A parallel faith in maximization is found in the cost–benefit and cost-effectiveness literature on health care allocation. The premise is borrowed from welfare economics and utilitarianism generally, according to which the goal of social policy should be to maximize the total sum of individual welfare or utilities. That we should maximize health does not follow, however, from the claim that we should maximize welfare; health is only one aspect of welfare, and maximizing welfare may require permitting individuals to strike their own tradeoffs between health and other goods, as their values and preferences dictate. Therefore, the view that health policy should aim at maximizing health is the local application of a general principle of justice; it is not derived from the general principle. The view stands or falls on its own merits and not with the general principle. Nonetheless, some of the arguments for and against utilitarianism have their parallels here.

Although maximizing health may be thought of as an imperative of efficiency, philosophers have also given serious attention to maximizing principles as candidates for principles of justice or equity. The fundamental moral assumption of maximizing principles is that we express equal respect for each person by giving her interests the very same weight as others. Behind a maximizing principle is a principle of equality: each person's interests, in this case their health, counts just as much and no more than anyone else's. From this perspective, an improvement in health for the well-off is just as valuable and carries the same moral weight as an improvement in health for the worse-off. Health benefits count equally no matter where they fall. Although a maximizing prin-

ciple so understood is a theory of distributive justice, it is sometimes said to be a principle of "distributive neutrality" because it directs us to maximize sum total amounts without regard to how that total is distributed.

In the empirical literature on class inequalities in health the goal of maximizing health is sometimes run together with the goal of equalizing health between classes. *The Black Report,* for example, argues that "eliminating social inequalities in health offers the greatest opportunity for achieving overall improvement in the nation's health" (Townsend and Davidson 1982, 200). Similarly, Wilkinson (1996, 16) suggests that our overriding aim should be to "increase the sum total of health of a society" by narrowing health inequalities.

Whether pursuing one of these goals will in fact promote the other simultaneously is an empirical question. Deciding on the goal we should pursue if we must choose between them, however, is an ethical question. There is no reason to think, a priori, that the goal of maximizing health is most efficiently pursued by attempting to narrow class inequalities in health. Even if this proves to be the case, we can ask whether the maximizing view accurately captures the moral concern many share over class inequalities in health.

Our belief is that many people will feel that a maximizing principle fails to explain what is objectionable about the data. It does not entail the view that class inequalities in health are necessarily unjust, and it assigns no special moral urgency to eliminating them. Those who attach importance to eliminating class differences in health for reasons of justice are likely to give priority to policies with that goal, even if they divert energy and resources from other programs devised to increase the sum total of health.

Equity as Equality

The second view proposes that it is unfair *in and of itself* that those of a higher socioeconomic status will, on average, live longer lives, in better health, than those of a lower one.

In support of this view, we might appeal to a principle of the moral equality of persons, as the maximizing view does, but to a different interpretation of that principle. We might argue that treating each person's interests as having the same weight or importance as everyone else's does not imply that improvements in health for the best-off are as

valuable as improvements in health for the worst-off. Instead the principle of respect for the moral equality of persons entails the view that people are owed roughly equal prospects for a good life, including prospects for a long and healthy life. Improvements in health for the better-off are therefore not as valuable as improvements in health for the worse-off—and this is true because of, not in spite of, the claim that their interests matter equally from the moral point of view. Because their interests matter equally, we should seek to equalize what is in their interests, like their health.

This view might best capture the common intuition that class inequalities in health are morally wrong. Recall, however, that this intuition does not necessarily extend to comprehensive egalitarianism, defined as the elimination of inequalities in income, wealth, and other resources generally. Can one consistently advocate equality as a principle of distribution for health without committing oneself to an unrestricted principle of equal distribution? The principle underlying egalitarianism in the domain of health would seem to be that justice requires a society in which people have roughly equal prospects for a good life. This principle, however, extends far beyond the domain of health.

It is helpful to return briefly to the issue, raised above, of whether or not health is special in the context of our discussion of the principles of maximizing and equalizing health. Both the maximizing and the equalizing principles are supported by appeals to interpretations of a more fundamental moral principle: the moral equality of people. This "deep" principle, however, gives us no reason to treat health in a distinctive way. Moreover, it offers no reason to believe that class inequalities in health might raise different and more urgent moral concerns than those raised by other kinds of health inequalities, such as the different life expectancy of men and women.

Nevertheless, reasons for counting inequalities in health as unjust can be found within egalitarian theories of justice, and these reasons apply particularly to class inequalities in health. The central claim for egalitarians is that respect for the moral equality of people entails that people should have roughly equal prospects for a good life and that inequalities in those prospects require special moral justification. Equality of life prospects functions as a moral baseline or default position. In some cases, and for certain reasons, deviations from the default position of equality may be morally justified, although each deviation requires a convincing argument. For example, Rawls's theory offers a moral justi-

fication for limited inequalities in income and wealth based on the effect of incentives in boosting productivity. Rawls argues that inequalities in the distribution of income and wealth are morally justified if they improve everyone's position (in terms of purchasing power), including the position of the worst-off, from the baseline of equality. Thus a just society, for Rawls, might not be a strictly equal society. This justification for inequality, however, extends to departures from equality only for the goods of income and wealth. Inequality in other goods, like basic rights, opportunities, or health, would have to be morally justified on other grounds.

According to this view, we should conceive of inequalities in income and wealth as special exceptions that we establish to a general principle of equality. In this sense, "class" is special and health is not, but *class* inequalities in health are also special because they are an unjustified consequence of our departure from the moral baseline; health, unlike income and wealth on our assumption, should be regulated by the baseline principle of equality. If the income differences that serve us through their incentive effects also have the undesired effect of burdening the less well-off with disease and premature death, the latter would be an unjust "cost" of the incentives, borne largely by those who least benefited from the resulting economic inequalities.

Perhaps this explains why class inequalities in health may be viewed as impermissible, even in a society that is otherwise just—in particular, a society marked by inequalities in other goods that are morally acceptable. It does not, however, show that only class inequalities in health count as injustices because other inequalities, like those associated with race, may qualify as unjust on other grounds.

Equity as Maximin

A third view on class inequalities in health is that these inequalities are not unjust per se; what is unjust are the low, absolute levels of health of members of society when this can be avoided. Justice, according to this view, is not concerned with people's *relative* position, whether in health, well-being generally, or resources, but rather with their absolute levels. We should feel the same urgency to improve the health of the least advantaged group, even if no one was better off .

Maximin principles of justice reflect this concern: they direct us to maximize the minimum position, regardless of how this affects the gap

between the minimum position and other positions. If we define the minimum position in terms of those who have the lowest socioeconomic status and apply maximin in the area of health, then it tells us to maximize the health of the lowest socioeconomic group, regardless of whether this increases or decreases inequalities in health between classes. Thus, society's distribution of health can be assessed as just or unjust only by comparing people's level of health relative to the level that could be achieved under alternative social policies. What matters is not who is doing better than whom, but how well each *could* be doing.

One reason for claiming that justice is concerned with absolute, rather than relative, levels of health is that each of us would prefer a world in which we had more years and better health to a world in which we did not, even if in the first world others lived longer and experienced a better state of health than ours, whereas in the second world their health was equal to ours. Except for "positional goods," we prefer more rather than less for ourselves, even if having more makes us worse off relative to others. Rawls expresses this idea by assuming that principles of justice are chosen by people who are "mutually disinterested"; they care about doing as well for themselves as possible, and they care not at all (they are neither envious or altruistic) about how others are doing.

Moreover, our moral obligations to others seem closely tied to people's absolute position rather than to their relative standing. As Joseph Raz argues:

> What makes us care about various inequalities is not the inequality but the concern identified by the underlying principle. It is the hunger of the hungry, the need of the needy, the suffering of the ill, and so on. The fact that they are worse off in the relevant respect than their neighbors is relevant. But it is relevant not as an independent evil of inequality. Its relevance is in showing that their hunger is greater, their need more pressing, their suffering more hurtful, and therefore our concerns for the hungry, the needy, the suffering, and not our concern for equality, makes us give them priority. (Raz 1986; cited in Parfit 1991)

According to a maximin principle, therefore, we should adopt those social policies under which the lowest socioeconomic class has the highest health possible, but not with the goal of achieving equality. To be sure, policies aimed at improving the health of the worse-off are, in practice, bound to narrow class inequalities in health status. Nonethe-

less, the motivations behind a policy of equality and a policy of maximin are very different. And only the maximin policy justifies giving priority to the worst-off, as opposed to a focus on all class inequalities in health, including that between the moderately well-off and the rich.

A principle of maximin applied to health raises the same question as the first two principles: why should we maximin health and not welfare or resources more generally? We will not pursue this complicated question here, although we return to it in the next section, where we discuss the effect of degrees of income inequality on health.

There is another problem with a principle of maximin, whether applied to health in particular or to well-being or resources generally. Is it plausible to give absolute priority to improving the health of the worst-off class if those who are next to the worst-off are also doing very badly? And what if even the best-off in a society are also doing miserably, with short life expectancies and poor health? Conversely, a maximin principle looks less appealing when applied to a society in which the most deprived are doing very well, with a generous average life expectancy. These reflections suggest that we intuitively apply some standard of urgency to levels of health that is not captured by maximin's concern only with amounts, rather than what those amounts "mean" for people's lives. If it is true that absolute, rather than relative, levels of health matter, then it is also true that they matter *more* when they are low.

Equity as Priority to the Sickest

Thus far we have discussed principles of (a) maximizing the total sum of health of a society, (b) equalizing levels of health between classes, and (c) maximizing the health of the lowest socioeconomic class. The fourth view takes as its point of departure the criticism of maximin offered above. There we suggested that people intuitively apply some standard of urgency to levels of health and not to the minimum position itself. In Raz's words, we care about the neediness of the needy and about those in the minimum position only in proportion to their neediness. Indeed, the urgency of needs suggests its own minimum position: those who are threatened with the worst harms—who have the shortest life expectancy and most serious diseases and injuries—should count as "the worst-off." Therefore, we should not give priority to the lowest socioeconomic class, but to those with the most urgent needs, regardless of class.

We can bring out the distinctive features of this view by constructing a contrary-to-fact example. Suppose there exists a society in which most members of the upper classes live long, healthy lives, but a small number are stricken with a terrible disease and die young. Few members of this imaginary society's poorest classes escape illness and premature death, but none suffer as badly as the unlucky few in the upper classes. The average health and longevity of the lower classes, then, will be considerably lower than that of the upper classes; but the worst-off *individuals*, at least in respect to their health, will be upper-class. On the fourth view, we should give priority to eliminating and treating the terrible disease of these richer sufferers because they are the worst-off. Such policies that would widen the gap in average health status between the classes would be justified, according to this fourth perspective.

To be plausible, such a principle must claim that the urgency of needs should have relative, not absolute priority (Parfit 1991). The point is not that resources should be expended on the sickest people, without any limitation on the ground of cost or lack of benefit—this is the bottomless pit problem addressed by Arrow. Rather, this view calls for a relative weighting: more urgent needs receive more weight when we balance needs against other factors, including cost and efficacy in our policy decisions. Giving needs relative rather than absolute priority also avoids the objection we raised to maximin: that it ignores the health status of everyone except the worst-off.

This fourth alternative suggests that class inequalities in health are the wrong focus of our concerns. But insofar as urgent needs are much more prevalent among the lowest classes, the real-world effect of such a policy would be to reduce those class inequalities.

Inequality as a Cause of Illness

According to Wilkinson and others, a society's degree of income inequality is an important determinant of health. While we do not argue for or against Wilkinson's hypothesis, we pause to note its significance for the issue of justice and health inequalities.

As we have discussed above, a maximin principle of justice applied to income and wealth (such as Rawls's "difference principle") may actually require inequalities in those goods should this turn out to increase the shares of those with the smallest allotment (as occurs

when a system of incentives produces more wealth that can be shared). The goal is the improvement of the smallest share, or the position of the worst-off, even if to meet this goal we must increase the distance between positions.

Given Wilkinson's hypothesis, a maximin principle of this kind is less appealing when considering its possible consequences for health. If health is correlated with less inequality in income, then a maximin principle applied to income could come at the cost of losses in health. It is impossible to say what the *net* effect of such a policy would be on health. On the one hand, the worst-off, we are to assume, have better purchasing power and a correspondingly higher standard of living. On the other hand, their position relative to others may be worse. Because richer countries seem to be, on average, less healthy than countries that have somewhat less wealth but also less inequality, the tradeoff might well be unfavorable. It is a surprising and unwelcome result that a maximin principle raises this concern.

This consideration suggests a kind of paradox about views of justice that differ over whether relative, as opposed to absolute, positions matter. If justice is concerned with *absolute*, not relative, levels of health, then justice must be concerned with *relative*, rather than absolute, levels of income and wealth.

Personal Responsibility for Health

One consideration complicating any attempt to locate the source of injustice in class inequalities in health is the notion that people bear some responsibility for their own morbidity and mortality. That much of the illness we suffer from can be traced to "lifestyles" is beyond questioning. Better health habits would do more to keep us alive and healthy than medicine can possibly accomplish. To the extent that differences in health status reflect choices for which individuals bear responsibility, how can these differences be construed as injustices?

Rawls's theory of justice was challenged by the libertarian philosopher Robert Nozick (1974), in part because individual choices would, over time, change any patterns of distribution that a society might establish in the name of distributive justice. Whether the distribution is based on equality, or on maximin, or any other pattern, people's everyday choices are bound to produce a different pattern if they are

allowed to trade, give, barter, and squander. Nozick's argument applies also in this consideration of justice and class inequalities in health. Even if we could eliminate, through social policies, those inequalities in health that we consider unjust, the resulting pattern of distribution of health states and life expectancies is likely to be upset as people pursue their very different lifestyles. The pattern that emerges over time may bear little relation to the just pattern that may have once been achieved through deliberate social intervention. Ought we to regard the new pattern as unjust, and thus in need of further intervention and rectification? Or, to the extent that it reflects free and informed choices by those affected, is justice preserved?

If we pursued this analogy in the direction taken by Nozick's critique of Rawls, we might conclude that justice requires no particular pattern of distribution of health states at all—in particular, no reduction of class inequalities in health. But this conclusion would be unwarranted for several reasons: First, much illness and excess mortality does not have a behavioral origin. Second, as we have mentioned, class inequalities in health remain after holding risk-taking behavior constant. Third, and just as important, the central premise of the Nozickian argument—that those engaging in unhealthy lifestyles are responsible for their choices—cannot be taken at face value (Lynch, Kaplan, and Salonen 1997). Some of these "choices" may reflect biological factors that an individual cannot be expected to rein in, such as a familial tendency to obesity. Others result from addictions (even if the original decision to try the addictive drug may have been a free one), or stem from a lack of opportunities to adopt healthier habits.

Moreover, it is not clear that we should hold people responsible for making choices that are normative in their particular social milieu. John Roemer (1995), an economist and philosopher, has argued that unhealthy choices made by large numbers of people in a particular social stratum ought to be regarded as products of that class structure, and the individual should not be held responsible for the risks taken so long as the individual's risk-taking was not greater than others in that same stratum. Whether or not we accept Roemer's thesis (T.M. Scanlon [1995] has commented on its seeming implication that working-class people behave unfreely much of the time), the "lifestyle" argument does not get off the ground unless it is clear that the risky behavior resulting in injury, death, or illness is voluntary. The argument trades on many other questionable premises as well (Wikler 1978).

The concept of personal responsibility for health bears on social policy aimed at class inequalities in health status. One powerful argument in favor of social interventions to ameliorate these inequalities, and indeed for regarding health care as a human right, is that illness and premature death are generally deprivations visited upon people through no fault of their own. For this reason, those who suffer because of bad health are entitled to the sympathy and aid of their fellow citizens (LeGrand 1991). If, however, we are personally responsible for health, and therefore for illness and premature death, then these deprivations cannot be said to have occurred "through no fault of our own" (Culyer and Wagstaff 1993). Such a premise undercuts this powerful altruistic argument and removes some of the fuel for an engine of social change that would seek to eliminate these inequalities.

Conclusion

Class inequalities in health are intuitively offensive. The import of research documenting the extent of these differences in health status is clear: if we can do something about them, we should. Nevertheless, we believe that although the serious injustice of these inequalities may be apparent, the precise nature of the injustice is not. We have initiated an analysis of the moral issue, identifying four distinct wrongs that might be thought to lie at the heart of the injustice. Choices among social interventions that target these inequalities might be affected by our view of the particular wrong these policies are designed to correct. Moreover, any attempt to declare an ideal for the distribution of health states must address a number of complicating theoretical considerations, like personal responsibility for health and the selection of health, among all social benefits and elements of human well-being, for equal distribution.

This is an exploratory paper whose modest goal is to point to uncertainties that have not been fully discussed in the burgeoning literature on class inequalities in health. We will present our own view, one that emphasizes absolute gains in health, rather than relative health statuses, on another occasion. Here we argue only that the documentation of class inequalities in health does not in itself identify the source or the nature of the moral problem whose existence they evidently demonstrate.

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