Inequality in political philosophy and in epidemiology: a remarriage

# Nir Eyal. *Very rough draft. Definitely don’t cite. Try not to remember.*

# Abstract

In political philosophy and in economics, unfair inequality is traditionally assessed between individuals, often nowadays on luck-egalitarian grounds. You have more than I do (through no fault of my own) and that’s unfair. By contrast, in epidemiology and sociology, unfair inequality is traditionally assessed between groups. More is concentrated among people of your class or race than among people of mine, and that’s unfair. Accordingly, political philosophers employ a univariate measure of inequality focused on welfare, money, capabilities, access, or another ‘currency’; epidemiologists employ a bivariate measure that is focused on checking for correlation between such a ‘currency’ and social advantage, e.g. being rich or white. I shall call this an egalitarian ‘divorce’.

Epidemiologists, and their ‘divorce lawyers’ Paula Braveman, Norman Daniels, and Iris Marion Young, explain that not every inequality between individuals is an inequity. Only inequalities between social groups are unfair. Only these inequalities link to partiality, discrimination, oppression, inequality-related population health problems, and unfair distribution of prospects. They alone are actionable. By contrast, inequality between individuals, e.g. in longevity, is natural, inevitable, less important, or otherwise less informative—not unjust.

I start this paper by responding to the epidemiologists in ‘divorce trial’ mode, that group inequalities lack the intrinsic disvalue that they ascribe them. Group inequalities may be instrumentally or contingently bad or wrong, not essentially. I then shift to ‘remarriage.’ Although group inequalities lack intrinsic import, for multiple reasons they remain useful to measure. Indeed, one reason is their tendency to generate extreme inter-individual luck-egalitarian inequalities—extreme enough that the injustice of all luck-egalitarian inequality comes into full relief.

# *Introduction*: An egalitarian divorce[[1]](#footnote-1)

When political philosophers and economists discuss unfair inequality, the inequality they are talking about is usually between individuals, and often of a luck-egalitarian stripe. You have more than I do (through no fault of my own). Other things equal, that’s unfair.

Not so in epidemiology and sociology. There, unfair inequality is usually measured between groups. More is concentrated among people of your race or class than among people of mine. That’s unfair or, as they more often put it, inequitable.[[2]](#footnote-2)

Accordingly, political philosophers and economists employ a univariate measure of inequality that assesses only the distribution of advantage, access, resources, or some other ‘currency’. Epidemiologists employ a bivariate measure. They assess correlation between the distribution of such a ‘currency’ and social stratification. What matters to them is not simply the difference between the individuals at the bottom and those at the top in some respect (to cite one approach to measuring inter-individual inequality), but instead, what kinds of people—what social groups—tend to be at the bottom and what kinds tend to be at the top. As one group of epidemiologists put it,

Equity is not the absence of all disparities; it is the absence of systematic disparities between social groups that have greater and lesser degrees of underlying social advantage because of such factors as wealth, sex, race and ethnicity, or urban and rural residence, for example. Policy makers need information on health inequalities between different social groups ([Almeida et al. 2001](#_ENREF_2)).

Political philosopher Iris Marion Young, who concurs with the epidemiologists, explains that in order for an inequality to be a central concern of distributive justice, that inequality must be a

structural inequality [which] consists in the relative constraints some people encounter in their freedom and material well-being as the cumulative effect of the possibilities of their social positions, as compared with others who in their social positions have more options or easier access [*qua* members of disadvantaged social groups] to benefits ([Young 2001, 15](#_ENREF_50)).

Epidemiological work on inequalities usually focuses on inequalities with ‘a social gradient’. To illustrate, a recent report on health inequalities in the European Union reveals many inequalities between social groups, both inside European countries and between those countries, for instance:

Life expectancy at age 25 for men with tertiary education in Estonia was 17.8 years longer, or 50% higher, than life expectancy for men who did not complete secondary education... In contrast, in Malta, Norway, Sweden and Italy the differences between the same two groups ranged from 3.2 to 5.2 years, which is 6–10% ([Marmot 2013b](#_ENREF_29)).

That report does not measure (preventable) differences in life expectancy between individuals, but between educated men and less educated men—two groups.

Or, to give a smaller scale example, a group of American neurologists have recently exposed differences in the incidence of ischemic stroke among 60-74 year olds between Mexican American residents of Corpus Christi, Texas and non-Hispanic white residents in the preceding decade. The rate ratio was consistently 1.50. They call that difference between population groups in town a ‘disparity’ and make no attempt to assess inequalities between the individuals—say, whether frequently the same person suffered multiple strokes while others were completely spared ([Morgenstern et al. 2013](#_ENREF_30)).

To reflect the explicit epidemiological concern with inequalities only between groups that are defined along lines of social advantage and disadvantage (not, e.g. *People who wear their right shoe first*), let us call the object of that concern ‘inequality between status groups’.[[3]](#footnote-3) A number of epidemiologists have further clarified that by calling only status-group inequality an ‘inequity’ they absolutelymean to suggest, first, that such inequality is inherently unjust in a morally loaded sense ([e.g. Braveman 2006, 182-3 gives Rawls's and Sen's theories of justice as illustrations of what she means by 'justice'](#_ENREF_6))—presumably not only instrumentally or contingently problematic—and second, that inter-individual inequality matters less. As they often put the latter point, ‘not every inequality is an inequity’, and inequality between individuals is *not* an inequity. A concern about injustice that, as such, can command great urgency ([Young 2001, e.g. 7](#_ENREF_50); [Daniels 2007](#_ENREF_12); [Braveman 2006](#_ENREF_6)).

I call this interdisciplinary divide, between inter-individual egalitarianism and status-group egalitarianism, an egalitarian ‘divorce’. Section I of this paper summarizes some defences of status-group egalitarianism. Section II argues, in ‘divorce trial’ mode, that these defences founder. In my own view, status-group inequality isn’t inequity, because it is not as such intrinsically unfair. Section III is conciliatory. Its business is egalitarian ‘remarriage’. It concedes that status-group inequality often remains useful to measure. Indeed, it is especially useful to measure from an inter-individual egalitarian viewpoint—so these two egalitarian approaches are mutually-reinforcing.

# I. Defences of focus on status-group inequality

Arguments for status-group egalitarianism seek to establish either that measuring such inequalities is important or that measuring inter-individual inequalities is unimportant. These arguments are medical, pragmatic, or philosophical.

## The epidemiologists’ medical arguments

Much of Michael Marmot’s scholarship consists in arguing that a ‘social gradient’ tends to make societies less healthy ([Marmot 2004](#_ENREF_27); [CSDH 2008](#_ENREF_10); [Marmot 2013a](#_ENREF_28)). Social epidemiologists argue that inequality is bad for health. The inequality in question is usually between status groups—the sort of inequality that epidemiologists traditionally oppose ([Wilkinson 2001](#_ENREF_46)). The initial case for attention to social inequalities is therefore quite simple. To quote Daniels’s slogan, ‘*In effect, social justice in general is good for population health and its fair distribution*’ ([Daniels 2007, 82, original italics](#_ENREF_12)).

## The epidemiologists’ pragmatic arguments

Status groups are sociologically salient. One reason why *people who wear their right shoe first* is not a social status is that such people are not recognized as a social category. One practical defence of focus on status-group differences is precisely that social status groups are salient to us. Their differences are easier for us to detect, measure, and operate on, than inter-individual differences. If for example inequalities prevail between social groups like urban and rural residents, then they are likely to be noticed, and it follows straightforwardly that interventions are needed in rural clinics, and that prioritizing rural residents for service eligibility should be considered. By contrast, differences between individuals cannot be gleaned without access to private individual data. And knowing that the difference between individuals is large says nothing about where to intervene and what kinds of people to prioritize ([Braveman 2002](#_ENREF_5); [Braveman, Starfield, and Geiger 2001](#_ENREF_8)).

Another pragmatic reason cited consideration for measuring status-group inequalities is that these inequalities point to relatively preventable health gaps, which are relatively easy to address. When longevity or resource uses vary along racial lines, it is usually pretty obvious that racism or discrimination lie in the background, not a biological ceiling on what can be achieved. There is no biological reason why African Americans or Medicaid patients should be referred to intensive care less than other Americans with similar indications ([Institute of Medicine 2002](#_ENREF_23)). Therefore, the argument continues, even setting aside moral concerns about discrimination, pragmatically, a sizeable health windfall could come from attention to and reduction of status-group inequality. Simply stopping to discriminate could do a lot for the health of disadvantaged groups. By contrast, inter-individual differences, e.g. in longevity, can reflect insurmountable biological problems that are less preventable ([Whitehead 1992](#_ENREF_45); [Daniels 2007](#_ENREF_12)).

## The epidemiologists’ philosophical arguments

While for some epidemiologists, terms like ‘disparities’ or even ‘inequity’ may have come to be purely descriptive names for differences between status-groups, for many others, and for their philosopher allies, these terms, and the differences that they designate, emphatically connote injustice ([Braveman et al. 2011](#_ENREF_7)). These authors focus on differences between groups for reasons that are in part ethical or philosophical.

A common moral argument for status-group egalitarianism assumes that injustice requires active agentic interventions like violence, discrimination, or oppression, or at least highly partial decision making—conscious or unconscious agentic bias ([Pogge 2002](#_ENREF_35)). Such emphasis on agency is why the human right to ‘nondiscrimination, referring to the right not to experience discriminatory treatment based on one’s social group,’ is said to justify the focus on status group differences ([Braveman 2006, 183](#_ENREF_6)). And it is on that ground that correlation between health status and race in the United States is often said to be ‘unjust’ thanks to its causal roots in ‘grave injustices’ ([e.g. Hausman 2013, 96-7](#_ENREF_22)). Associating justice with histories of maltreatment is important to Norman Daniels. For instance, writing on race and gender-based health inequalities everywhere, he adds: ‘Since these kinds of inequalities are the result of social exclusion and other unjust practices aimed at vulnerable groups, we are generally and justifiably inclined to view them as inequities’ ([Daniels 2007, 81](#_ENREF_12)).

Supporters of this approach are quick to point out that discrimination and oppression are sometimes unconscious or unintentional. But many insist that at a minimum, injustice consists in the cumulative effects of ‘structural’ or ‘systemic’ differences—differences between social groups due to persistent social factors—on group members’ options and opportunity sets ([Young 2001](#_ENREF_50)). Supporters of status-group egalitarianism then explain that what makes group differences unjust is precisely their tendency to stem from such subtle social oppression ([Young 2001](#_ENREF_50)). The WHO Commission on the Social Determinants of Health seems to define inequity with such deep social structures as necessary conditions: ‘Inequity in the conditions of daily living is shaped by deeper social structures and processes. The inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources’ ([CSDH 2008, 10](#_ENREF_10)).

Not so, status-group egalitarians then point out, for many inter-individual differences in health. Those can easily stem from mere coincidence or from individuals’ sheer biological constitutions. One individual is hit by a car and another isn’t; one turns out to carry chromosomal abnormalities and another doesn’t. And, since according to many status-group egalitarians’ ethical suppositions, ‘natural, biological variation’ cannot constitute *unfair* inequality ([Whitehead 1992](#_ENREF_45))—it is a mere fact of life—they conclude that inter-individual differences matter less.

Philosopher Norman Daniels, who takes the epidemiologists’ side on this, argues elegantly against egalitarians who demand simple equal access to advantage—a view later endorsed by some luck egalitarians ([Cohen 1989](#_ENREF_9))—for focusing on trivial differences that may not even merit the name ‘inequality’.

There is a coffee machine in a lounge not far from my office. When is access to the coffee equal among my colleagues? Some cases seem clear: if the lounge is open only to male colleagues, then female colleagues can complain they do not have equal access to the coffee. If the lounge is up a flight of stairs and there is no wheelchair ramp, then my paraplegic colleague may have grounds for claiming unequal access to the coffee… Other factors have a less clear impact. Should we worry about the fact that not all offices are equidistant from the pot? ([Daniels 1985, 61](#_ENREF_11))

Absent social differences, a small difference in access to a good is not unjust, but a social gradient can render it more significant and a true injustice.[[4]](#footnote-4)

Some status-group egalitarians invoke *Ought Implies Can* to argue that natural inequalities and the related natural differences between individuals aren’t unjust *at all*. There is *nothing* ‘immoral’ about the cosmos developing in one way or another*.* The differences between us do not count as unjust when they are in no way amenable to human intervention—when we couldn’t mitigate them. To count as inequities differences in health must be ‘unnecessary and avoidable’ ([Whitehead 1992](#_ENREF_45)). Thus, ‘If an incompensable health inequality such as that between a healthy person who lives to 85 and a child who dies in infancy cannot be mitigated—that is, remedied or compensated—by any human actions, then the inequality is not an injustice’ ([Hausman 2007](#_ENREF_20)). For Norman Daniels, what makes socially determined health differences unjust is in part that they are socially not naturally determined: ‘To the extent that these social determinants are socially controllable, we clearly face questions of distributive justice’ ([Daniels 2007, 81](#_ENREF_12)). Even some inter-individual egalitarians accept that inequality that we could in no way redress are not unfair ([Norheim 2013](#_ENREF_33)).

A third philosophical defence of focus on status groups is that difference between such groups often means that individuals from the worse off group are locked in a ‘bird’s cage’ of social forces that inhibit their choices and opportunities ([Young 2001](#_ENREF_50)). The poor might be formally eligible for elite education and Latinos in Corpus Christi, Texas might be formally eligible to healthy diets. But powerful social forces keep them out. Both liberty and equal opportunity suffer when social structures create differences between groups. The underrepresentation of the poor as a group, and high rates of strokes among Latinos, are smoking guns, if you will, that indicate this ‘structural violence’.

A final philosophical defence is that difference between groups means that individuals have unequal chances in life *as* group members. Whether the sources of status-group inequality are social or other, the thought here is that individuals have claims to fair chances ([Daniels 2013](#_ENREF_13)); inequality between groups imposes unfairly elevated risk on those individuals who belong to worse off groups, *as* members of those groups (Braveman ==). For example, in America, stark differences between black and white children (defined as 5-14 year olds) mean that the chance of a black child to survive for a year is only 2/3 that of a white child ([Singh 2010](#_ENREF_40)). Intuitively, that seems grossly unfair. It seems unfair not only toward those African-American kids who will die in the course of the year and so, will suffer a terrible outcome as individuals. Before we even know how the chips will fall: which individuals will live and which will die, it already strikes us as unfair—we call it a disparity—that a black kid, through no fault or choice of her own, has far worse survival chances for the year. So understood, the unfairness inheres in the distribution of mortal risk (not only in the actual bad outcome of death) precisely in virtue of inequalities between American racial groups.

# II. Divorce trial

I am a political philosopher with luck-egalitarian sympathies. This section builds an initial case for the injustice of these inter-individual inequalities and against status-group egalitarianism, then responds to the expected push back from status-group egalitarians.

## Opening shot

The basic case for luck-egalitarian concern about inter-individual differences, that the worse off could not prevent should be familiar ([Temkin 2003b](#_ENREF_42); [Cohen 1989](#_ENREF_9)). Imagine that naturally, through no one’s choice, one island winds up with far fewer coconuts than an otherwise similar island. One islander is relatively poor and her life goes worse, through no fault or choice of her own. This feels to me suboptimal in some morally-relevant way. Intuitively, it’s an opportune development, a morally good thing, if by total natural fluke, some coconuts float from the island of plenty to the island of relative deprivation. Certainly it is better than if they float in the other direction. This holds whether the two islanders are below sufficiency level or above it, whether they share a history and a sense of community or they had never met, whether coconuts exhibit decreasing marginal utility or not. If luck-egalitarian equality can be restored without counterproductive or other bad effects, more luck-egalitarian equality seems preferable. And, since the impact on aggregate utility is less clear than that preferability, presumably such a development would be good because the distribution is fairer ([Eyal 2007, 1-2](#_ENREF_16)).

Exclusive focus on intergroup inequalities fails to capture this consideration of fairness in full. It overlooks unfair inequality between group members Is there really nothing unfair when different individuals within a group fare very differently from each other ([Rae 1981](#_ENREF_37); [Murray, Gakidou, and Frenk 1999](#_ENREF_31); [Lippert-Rasmussen 2013](#_ENREF_26); [Asada 2013](#_ENREF_4))? To look at group averages alone is as inegalitarian as looking at averages only, with no attention to distribution, when assessing societies’ wealth and welfare—something that Amartya Sen has taught us not to do ([Sen 1992](#_ENREF_39)) and status-group egalitarians emphasize we must not do ([CSDH 2008, 1](#_ENREF_10)).

Importantly, both parties to the present debate accept that groups matter ethically only insofar as they affect individuals ([Temkin 1993a, 101](#_ENREF_41); [Young 2001, 6](#_ENREF_50)). The debate is only about the extent to which what I call status-group inequalities affect individuals unfairly as group members. In what follows, I shall argue that status-group inequalities do *not* affect individuals as group members in ways that matter intrinsically. But first, let me examine the case for status-group egalitarianism. I shall argue that, by contrast with luck-egalitarian inequalities between individuals, status-group inequalities aren’t always inequities, in one crucial sense: they are not always intrinsically unfair.

## Answering the medical arguments

One thing to observe about the medical argument is the difference between two senses of social inequality in health. In one sense, such social inequality designates differences in health status or access to health resources between social groups. In another, it designates differences in social spheres like income that, according to many social epidemiologists, cause health problems. Those health problems may accrue to the socially worse off, e.g. economic or ethnic minorities. But in principle they may also accrue to everyone, or to elite social groups. When the classical British Black Report argued ‘that eliminating social inequalities in health offers the greatest opportunity for achieving overall improvement in the nation’s health’ ([Townsend, Davidson, and Whitehead 1992, 200](#_ENREF_43)), presumably the first sense of ‘social inequalities in health’ was being used. But it did not entail that reducing the social gradient of health inequalities would substantially improve population health. Discussions of ‘social’ health inequalities tend to run together both senses ([Woodward and Kawachi 2000](#_ENREF_49); [Daniels 2007, 82](#_ENREF_12)). But the social inequalities in health that concern this chapter are of the first kind only. Social epidemiology findings on the connection between income differences and health problems do not directly establish that a social gradient to *health* creates health problems. According to Woodward and Karachi, one

line of argument emphasises that a reduction in health inequalities would bring benefit to others in the population besides those with the worst health. There is evidence to support this view from the history of public health… For example, investment in better housing may result not only in less respiratory disease and fewer house fires, but may lead also to less strain and violence in families, with consequent benefits to all members of society ([Woodward and Kawachi 2000](#_ENREF_49)).

The first quoted sentence seems to refer to social[[5]](#footnote-5) inequality in health in the first sense above. But the example seems to be one where what causes health problems and other problems to the population at large—strain and violence—is the causes of that health inequality, namely, health-unrelated inequalities in the spheres of housing.

Assume however that a health inequality with a social gradient also undermines population health. Still, not all consequent health problems would count as unjust inequities. First, some health problems, such as ones affecting *everyone* and ones affecting only the rich and generally healthy, do not constitute inequities. Severe hay fever that affects everyone *equally* is not an injustice. Hay fever that affects all and only residents of leafy, affluent *elite* neighbourhoods is not an injustice. These fevers are bad and we should redress them; but not because they are inequities. To show that something, including a health inequality with a social gradient, causes health problems is not to establish that it is an unjust inequity.

Second, even if status-group inequality typically brought about worse health for the socially disadvantaged and consequently tended to constitute an inequity, that causal connection would not *make* status-group inequality into an inequity. Rather, it would mean that status-group inequality is one causal source of inequity—something that is instrumentally bad, but isn’t *as such* intrinsically bad. There is a difference between constituting injustice and (typically) causing injustice.

## Answering the pragmatic arguments

Likewise, even if status-group inequality were always more useful as a measure of inter-individual inequality, that would not make it into an inequity—only into a better measure for one. There’s a difference between factors that objectively constitute a moral difference, and the most useful measures for those factors. Even if CD4 count is a great proxy for the progression of HIV/AIDS, it not the same thing as progressive HIV, better expressed as a high viral load. This is why if a better indication of high viral load presents itself, we might stop measuring CD4 density.

In our context, things other than status-group inequalities sometimes turn out to be more useful as proxies for certain health problems and their typical causes. Measures of air pollution and measures of car use are cases in point. Status-group inequalities can be useful measures of health concerns, but so can other things. Even combinations of status-group affiliations with less status-related social categories such as postcode turn out to identify some health gaps. In the United States, *Race+Postcode* homes in on clusters of health problems better than *Race* (or *Income*) alone ([Murray et al. 2006](#_ENREF_32); [Asada, Yoshida, and Whipp 2013](#_ENREF_3)).

So salient social hierarchies aren’t always uniquely good proxies for large or preventable health gaps. In fact, people with higher social status sometimes have distinctive health gaps that it is also important to identify and address. Among women in developing countries, those with high socioeconomic and educational status tend to smoke more, not less, than women of a lower status (==add cite). Focus on lower status women’s health issues would not be a pragmatic way to identity this health gap.

Sometimes, status-group inequalities identify a health gap, but one that is hard to fix. Not all health gaps with a social gradient are highly amenable to intervention. Some stem from risk factors that more deeply entrenched ([Eikemo and Mackenbach 2012](#_ENREF_15)). Even when social inequalities stem from sheer racism or misogyny toward a certain social group alone, they are *not* always easyto mitigate. A lot of racism and misogyny is hard-wired, perhaps the result of evolutionary biology or deep-seated acculturation and long-standing historical animosities. It can be harder to fix than certain biological obstacles to population health promotion (e.g. through adding micronutrients to wheat, salt or water). There are good reasons to fight racism, but the promise of a relatively easy fix is doubtfully among them. And many status group differences stem from historical racism, oppression, and discrimination, whose impact persists even after unequal treatment has ceased. Making treatment more equal would no longer fix them.

## Answering the philosophical arguments

The philosophical case for status-group egalitarianism is shaky as well. Let me discuss separately the alleged causal background of status-group inequalities, and their connection to unequal chances.

*The alleged causes of status-group inequality*

First, some status-group inequalities do *not* result from anything like intentional discrimination or the other agentic social maltreatment that, for some status-group egalitarians, is necessary for an outcome to constitute an injustice. The main sources of inequality between sexes in breast cancer rates are biological, not social. So are the main sources of interracial inequality in sickle cell disease. Muggy valley areas have higher malaria incidence than mountains, but that can reflect the laws of entomology not social science. Japanese-American women live longer than European-American women ([Murray et al. 2006](#_ENREF_32)), but surely not because they oppress European-American women.

Even if racist cruelty, intentional discrimination, or mere unjust ‘systemic’ processes were always in the causal background of status-group differences, such differences would not always be unfair toward *everyone* in the worse off status group. Take a case of outright intentional discrimination against speakers of Spanish in a US town. That discrimination creates status-group inequality between Latinos and other status groups in that town. However, it would be too fast to move from the worse state of Latinos as a group in that town to the claim that every Latino in that town, including even Portuguese-speaking Brazilians, suffers from unfair inhibitions to their opportunity sets (the disadvantage that Iris Marion Young attributes to all members of worse off groups). In this example, if discrimination is only against Spanish speakers and not again speakers of other foreign languages, Brazilians may suffer from no unfairness.

In addition, notwithstanding Pogge, Marchand, and others, it is usually inappropriate to prioritize victims of oppression and discrimination over people with equal needs, whose needs have other causal sources. Doctors do not and should not prioritize innocent victims of stabbings over equally-wounded innocent victims of ice stalactites accidental injuries. Nor should the health system encourage doctors to do so. Neither doctors nor the system ought to prioritize patients whose diseases have clear social sources—social violence against minorities, socially-induced unhealthy lifestyles—over equally ill patients whose diseases have strictly biological sources—certain congenital diseases ([see also Lippert-Rasmussen 2004, 213-5](#_ENREF_25)).[[6]](#footnote-6)

Group difference can be exacerbated through perfectly impartial decisions, and with no intentional oppression. A health ministry official may decide to locate a new hospital in a centrally-located city and not in underserved rural areas, because a centrally-located hospital would remain within acceptable reach for more patients. Whether or not her decision is justified all things considered, or even fair, it isn’t necessarily a reflection of partiality toward urban dwellers.

Or take a more extreme example. A health ministry official prioritizes rich white patients for a service over minorities simply because the former tend to be more efficient translators of resources into health and welfare—which is the case in many areas of healthcare ([CSDH 2008](#_ENREF_10)). What attracts the official is the gain in collective health and welfare that is likely to result, not the social gradient itself. Whether or not her decision is justified all things considered, or even fair, it isn’t necessarily a reflection of racism or any partiality. An impartial cost-effectiveness maximizing machine could make the same decision.

Honest supporters of focus on status-group inequalities concede that such inequalities do not always reflect *intentional* agency. They insist that they reflect unjust processes such as what they call ‘structural’, ‘systemic’ sources of inequality. But as the example of Japanese American and European-American women suggests, status-group inequalities sometimes reflect nothing of the sort—only benign processes that no one, including these supporters, would condemn as unjust.

Nor is it the case that every social impediment aligns with a social grouping. Stabbings by a congenitally psychotic individual are socially caused but they need not stem from ‘systemic’ social forces. And even systemic differences between status groups can stem from fluke differences, for example, between their geographical regions, and not from the difference in their advantage levels. A fluke natural disaster in rich city X can affect health, the housing market and economic standing, for many years. It can disadvantage residents of that city and make them less healthy than residents of poor city Y, without anyone’s planning or agency, and as a matter of fluke not systematic difference, and not as a matter of their prior economic differences.

*The alleged unfair impact of status-group inequality on chance distribution*

One argument for minding status-group inequalities does not depend on the causal source of these inequalities. That argument is that, when groups are unequal, the individuals comprising these groups face unfairly unequal chances. But this defence of status-group egalitarianism fails as well. For starters, note that *non*-status-group inequalities would also make individuals’ chances unequal in the same way. So this argument would not account for the epidemiologists’ emphatic focus on inequality between *status*-groups. Thus, inequality in hay fever rates between social elites who reside in pollen-rich leafy neighbourhoods and other citizens means that elite individuals face elevated risk of contracting hay fever as elite members. But this inequality does not seem unfair. It further follows that at least sometimes, imposing unequal chances on individuals as group members is not unfair.

The hay fever example may be dismissed because it involves a slight unfairness, easily overridden by the elite’s other, more important advantages in life. But consider the example of racial disparities among American children in mortal jeopardy, mentioned earlier. It is true that in one sense, black US children face a higher risk of dying next year *as black* than white US children do *as white*. But surprisingly, we shall now see that unequal risk in that sense poses no inherent moral concern.

But precisely which individuals can be said to face (unfairly) worse risk in such situations? Risks are not unfairly high for *all* U.S. black children. African-American children with millionaire parents usually have better survival rates than most white US children. In America, being a millionaire’s kid tends to make life very safe, and that tendency may overwhelm any risk that black millionaires’ kids face *as* black. So it is not the case that when chances are worse for African American children as a group, all African American children have worse chances as individuals.

In fact, since the statistical distribution is probably standard, one assumes that some fraction of black American children reside on streets that are in the following way the exception. Among residents of these streets, annual survival is far more frequent among black kids than among equally-rich white kids: so much higher that, in those exceptional streets, even controlling for income, black kids have on average better annual survival rates than white counterparts. In every such street, there is very clearly a sense of chance in which being black actually decreases a child’s risk of health during the year that follows.

Unfairness in the distribution of chance ‘as a group member’ is a misapplication. In our context, for any particular child whom we know is African American, it is wrong to conclude that his or her chance is unfairly lower than that of any white kid or the white average. Some of these black kids have very good prospects, safer horizons than the white kid average, thanks to millionaire parents, to living in an atypical street, and to other personal characteristics such as differences in the genetic makeup of different individuals whose existence or impact have yet to be discovered.

It is tempting to retort that the relevant unfairness accrues to those African-American children who are *really* at high annual mortality risk, given *all* the relevant facts: facts about inter-racial differences, about parents’ wealth, about genetic makeup, and about everything else that affects personal risk. Together, these causal factors will determine who is at high risk, and who isn’t.

But once all causal factors are taken into account, then, in a Laplacian world at least, the full set of causal factors at the beginning of a year determines who will live and who will die by the year’s end. It makes no more sense to separate personal chances in *that* sense from personal outcomes. In such a world, chances given all causally-relevant factors are co-extensive with outcomes. No childfaces (unfairly worse) chances without also facing worse outcomes ([Adler 2003, 1352](#_ENREF_1); [Otsuka 2011 draft, 5 n. 11](#_ENREF_34); [Frick 2013](#_ENREF_18)).

Now, we do not know all the factors that would affect individual children’s survival next year in America, and so we cannot tell for sure who will live and who will die by year’s end. Some unfairness might be thought to remain towards kids who survive the year but nevertheless were at high risk *for all we knew or had evidence for as the year began*. But why should epistemic risk differences be unfair, given that they can reflect merely our limited knowledge and evidence—error, and not objective matters? Racist discrimination in protection from risk is condemnable, even when it founders because it rests on false assumptions about how to protect from risk factors, is unfair. But remember our earlier point that partiality is only sometimes in the causal background of status group inequality. Remember also status-group egalitarians’ emphatic denials that intention to discriminate is necessarily in the background of status-group inequality ([Young 2001](#_ENREF_50))

Put more generally, a person’s chance as a group member may sound like an objective matter, but it wholly depends on how we divide up society into groups: whether we call a person *Estonian male* or *Educated Estonian male* may make all the difference to her chances *as a group member*. Partially overlapping social groups can fare very differently from each other; on pains of saying that a single person who belongs to both has both good life chances (as a member of a group that fares well) and bad ones (as a member of one that fares ill), we should not understand group differences as differences in any single person’s chances.

# II. An egalitarian remarriage

Notwithstanding this critique of status-group egalitarianism, let me suggest that there often remain good moral reasons to keep track of status-group inequalities.

## Causes or rough indicators of moral problems, including injustice

Even if they do not always constitute injustice, status-group inequalities quite often remain causes or convenient first indicators of various moral problems, including population health problems and even proper injustices. For example, when a highly perspicuous status-group inequality undermines social solidarity (e.g. by undermining feeling for the worse off among the more fortunate), it can undermine social cooperation and population health ([Wilkinson 2001](#_ENREF_46)). Group inequality can certainly stem from and indicate pre-existing poor solidarity. It follows that sometimes, status-group inequality causes or indicates problems. When the cost of doing so is moderate, it is therefore usually good to keep track of status-group inequalities.

Relatedly, while status-group inequality does not always reveal in which populations intervention would be helpful and its measurement is not always otherwise practical or helpful, and while such usefulness would not be the same thing as injustice, it quite oftenremains useful to monitor status group inequality, alongside inequalities between individuals ([Asada 2013](#_ENREF_4); [Norheim 2013](#_ENREF_33); [Hausman 2013, 98-9](#_ENREF_22)). First,

data about inequalities across groups are more readily available to policy makers than data about inequalities across individuals, and social policies to address inequalities across groups are more feasible than social policies to address inequalities across individuals. For these reasons, egalitarians often focus on inequalities across groups, even when they are mainly concerned about inequalities among individuals ([Hausman and Waldren 2011](#_ENREF_21)).

Again, the added usefulness of focus on status groups should not be overstated. Information about status group affiliation is not strictly necessary: ‘Data concerning the variance across individuals of health outcomes or expectations may give rise to inquiries whose findings could be of great importance to egalitarians’ ([Hausman 2013, 99](#_ENREF_22)). And even when some information beyond the sheer variance between individuals’ health helps, that information need not be about status groups. Correlation between health problems and status groups helps locate where to intervene, for example, but so does correlation with non-status based grouping: with other medical conditions, with non-hierarchical geographical groupings, and with other non-hierarchical demographical data.

Second, while status-group inequality does not always correlate with easily-removable health gaps or stem from intentional discrimination, oppression, partiality or the like, it often does. In places with a history of intentional discrimination it remains something to check for: a rough, initial indicator of these problems and hence of potentially redressable health gaps.

In short, while status-group is not always a useful measure for problems and while not all problems are injustices and not all measures of injustice are injustices, in various ways it quite often remains advantageous to keep track of status-group inequality.

## Perceived injustice

Status-group inequalities are often *perceived* as unjust, and *that* can breed frustration and undermine social trust and social capital. Some individuals will take injustice toward members of a minority group as a cue that the state or those in the know care little or disrespect that minority. That, in turn, could reduce their regard and beneficent treatment of that minority. It could also undermine adherence to norms of fairness and respect in general. For such reasons, reducing status-group inequality can make a lot of instrumental sense. What it doesn’t do is to make such inequality inherently unfair.

In addition, the fact that many, including decision makers and electorates, perceive social inequalities as particularly unjust can make it fruitful to protest that subset of injustices to them. Epidemiologists have argued that protesting these inequalities has often proven successful ([Braveman 2006](#_ENREF_6)).

## Proxies of Walzerian injustice

According to Michael Walzer, different goods should be distributed differently. It is unjust when one distributive sphere, such as money or political power, ‘dominates’ others, for instance, when money determines who will earn university degrees, medical care, or love. Even when income distribution is fair in itself, income should not command such ‘tyranny’. Walzer’s ideal of complex equality ‘means that no citizen’s standing in one sphere or with regard to one social good can be undercut by his standing in some other sphere, with regard to some other good’ ([Walzer 1983, 19](#_ENREF_44)).

In our context, a Walzerian might argue that many health inequalities are unjust because they reveal tyranny and violate complex equality. One good, such as income or education or the relative political power that can define certain status groups and come with urban residence or with some racial or gender affiliations, must not dominate others. Belonging to an ‘advantaged’ social group is already a social good of precisely that nature, and the distribution of that good should not determine that of goods in other spheres. But status-group inequalities mean precisely that advantage begets further advantage. On that reading, status-group inequalities are always violations of Walzerian complex equality.

An attraction of this account in relation to health is its relative robustness to the direction of the causal arrow between economic and health advantage, a hotly contested issue in relation to health inequalities. Even if inequalities in health stem mainly from the tendency of being healthy to boost earnings, as some have argued ([Deaton 2013](#_ENREF_14)), and not the other way around ([Marmot 2013b](#_ENREF_29)), the Walzerian could insist that one sphere—in this case, health and not money—dominates others inappropriately.

It would be mistaken to assume that every status-group health inequality reflects Walzerian tyranny. After all, correlation between spheres may be mere coincidence, or a reflection that both spheres are affected by a third factor that is not itself a distributive sphere ([compare Walzer 1983, 20](#_ENREF_44)). For example, both wealth and health sometimes stem from prudence, which is not a social good. Even so, such correlations are the exception and status-group inequality would remain a good *proxy* for Walzerian tyranny. Thus, if we agreed with Walzer that tyranny in his sense is always unjust, or at least a moral problem (a question on which this paper will not take a position), we would agree that status group inequalities are useful proxies, which ought to be monitored.

## Proxies of Roemerian injustice

John Roemer proposes to ‘pragmatic’ egalitarian social planners a ‘rule of thumb’—a proxy. Take risky behaviour that often leads to disadvantage, such as smoking. When such behaviour correlates with a socially-defined grouping, the pragmatic suggestion is to assume that that risky behaviour does not stem from fully avoidable choice. If all steel workers smoke, and many consequently contract lung cancer, it is usually best to treat their choice to smoke as brute luck; To assume that something other than fully avoidable personal choice (e.g. peer pressure, lack of health information) accounts for their choice. It accounts for it often enough to make it safe to treat such choices as unavoidable and compensate resulting disadvantage in full ([Roemer 2000](#_ENREF_38)).

If Roemer is right, it follows that any socially-defined group inequality is such a proxy. Status-group inequality that results from unhealthy lifestyle and other risk taking in a disadvantaged social group reflects the sort of risk-taking that pragmatic luck-egalitarians should *not* take to excuse disadvantage. In other words, status-group inequalities are proxies for a set of inter-individual inequalities that remain unjust. They are often useful measures for an inter-individual egalitarian standpoint[[7]](#footnote-7). Proxies of another luck-egalitarian injustice

Trying to shore up her group-inequality emphasis, Iris Young argues that social structures inhibit individuals’ choices and opportunities through those individuals’ social belonging. Young is right that these inhibitions are real, and that they raise genuine moral concern. But that concern can easily be construed as luck-egalitarian.

Luck egalitarians would say that that concern is about unfair distribution of chances and opportunities. Structurally-caused inhibitions mean that some individuals suffer from a worse opportunity set than others, through no fault of their own. The causal source of this inequality in chance may be social structure group affiliations, and so forth. But it is an injustice to the extent that it results in an inequality of advantage between individuals. Different opportunity sets for different people that are nevertheless equal in value, are not unjust (although they may be problematic otherwise, for example, when they indicate unnecessary limitations on freedom). Different opportunity sets of unequal value are, however, unjust according to luck-egalitarianism. Just like other inter-individual egalitarians ([Gakidou, Murray, and Frenk 2000](#_ENREF_19)), Many luck egalitarians are perfectly ready to compare individuals for life expectancy, health expectancy, and other chancy attributes which they treat as one more form of advantage (add cite==). For reasons that I describe elsewhere, I believe that chancy attributes do not make sense as currencies of egalitarians ([Eyal forthcoming](#_ENREF_17)). What is true, however, is that poor chances quite often translate into genuine disadvantage—for example, when individuals pay money for insurance to reduce high risk ([Wolff and de-Shalit 2007](#_ENREF_48)). Then, there can exist luck-egalitarian inequality between individuals, or just unnecessary waste and suffering.

## Proxies of repeat injustice

Far from competing with inter-individual inequalities, status-group inequalities are bad partly for tending to increase inter-individual inequalities, which *are* unjust. When groups defined along ‘greater and lesser degrees of underlying social advantage’ (as Almeida et al put it) have different concentrations of *further* advantage, that increases the frequency with which a comparatively advantaged individual is again the beneficiary, and he or she winds up even more advantaged than before; and the frequency with which an individual who was already disadvantaged gains nothing. In this way, status-group inequalities tend over time to increase inter-individual inequalities. When that status-group inequality is ‘systematic’—and it often is defined as systematic by status-group egalitarians ([Almeida et al. 2001](#_ENREF_2); [Young 2001](#_ENREF_50); [Powers and Faden 2008](#_ENREF_36)), this process recurs. More and more inter-individual inequalities take place, compounding the overall (that is, non-sphere specific) inequality between individuals. ‘Systemic’ differences between groups, which extend beyond a single ‘parameter’ tend to increase inter-individual gaps—and injustice.[[8]](#footnote-8)

Succinctly put, whenever an advantage goes to a privileged social group, inter-individual gaps tend to increase. Many ‘rounds’ later in a ‘systemic’ and hence recursive process, many advantages tend to have reached the haves and not the have nots. The overall gap between individuals tends to have increased by *a lot*. Inter-individual inequality is usually far greater. That’s a gross injustice from an inter-individual egalitarian standpoint.

For illustration, suppose that a religious group whose members typically (and with some exceptions) are relatively disadvantaged in terms of income is also doing worse off in terms of risk factors for lung disease, treatment for chronic pain, and housing. That means not only that overall intergroup inequality will be high. It also means that overall inter-individual inequality is likely to be high. It will usually be the case that individuals who are worse off in terms of income will have little or no counterbalancing advantage in other spheres. Their worse lots in the area of income will be compounded by worse lots in the area of lung disease, further compounded by worse lots in the area of chronic pain treatment, and further compounded by worse housing. By the end of the process, there will be a lot more people who are *much* worse off than others overall than there would have been absent this social gradient. That’s bad, from *any* plausible egalitarian viewpoint.

# Conclusion

Strictly speaking, only (unavoidable) inter-individual inequality is unfair. Status-group inequality is not inequity. But status-group inequality remains useful to measure. One reason why it is is its tendency to increase inequality between individuals—so that what is otherwise often a genuine but small inequity becomes large enough to compel attention—even the attention of those who fail to recognize its injustice in small portions.

# References

Adler, Matthew D. 2003. Risk, Death and Harm: The Normative Foundations of Risk Regulation. *Minnesota Law Review* 87:1293-1445.

Almeida, Celia, Paula Braveman, Marthe R. Gold, C. L. Szwarcwald, J. M. Ribeiro, A. Miglionico, J. S. Millar, S. Porto, N. R. Costa, V. O. Rubio, M. Segall, B. Starfield, C. Travassos, A. Uga, J. Valente, and F. Viacava. 2001. Methodological concerns and recommendations on policy consequences of the World Health Report 2000. *Lancet* 357 (9269):1692-7.

Asada, Y., Y. Yoshida, and A. M. Whipp. 2013. Summarizing social disparities in health. *The Milbank quarterly* 91 (1):5-36.

Asada, Yukiko. 2013. A Summary Measure of Health Inequalities: Incorporating Group and Individual Inequalities. In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, O. F. Norheim, S. A. Hurst and D. Wikler. New York: Oxford University Press.

Braveman, P. 2002. MSJAMA. Measuring health equity within countries: the challenge of limited information. *JAMA : the journal of the American Medical Association* 288 (13):1650.

Repeated Author. 2006. Health disparities and health equity: concepts and measurement. *Annual review of public health* 27:167-94.

Braveman, P. A., S. Kumanyika, J. Fielding, T. Laveist, L. N. Borrell, R. Manderscheid, and A. Troutman. 2011. Health disparities and health equity: the issue is justice. *American journal of public health* 101 Suppl 1:S149-55.

Braveman, P., B. Starfield, and H. J. Geiger. 2001. World Health Report 2000: how it removes equity from the agenda for public health monitoring and policy. *British Medical Journal* 323 (7314):678-81.

Cohen, Gerald A. 1989. On the Currency of Egalitarian Justice. *Ethics* 99 (4):906-944.

CSDH. 2008. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

Daniels, N. 1985. *Just Health Care*. Cambridge, New York: Cambridge University Press.

Daniels, Norman. 2007. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge UP.

Repeated Author. 2013. Reducing Health Disparities: No Simple Matter. In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, O. F. Norheim, S. A. Hurst and D. Wikler. New York: Oxford University Press.

Deaton, Angus. 2013. What Does the Empirical Evidence Tell Us About the Injustice of Health Inequalities? In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, O. Norheim, S. A. Hurst and D. Wikler. New York: Oxford University Press.

Eikemo, T. A., and J.P. Mackenbach. 2012. EURO-GBD-SE: The potential for reduction of health inequalities in Europe. Final report, part I. Rotterdam: Erasmus MC: University Medical Center Rotterdam.

Eyal, Nir. 2007. Egalitarian Justice and Innocent Choice. *Journal of Ethics & Social Philosophy* 2 (1):1-18.

Repeated Author. forthcoming. Concentrated risk, Coventry Blitz, Chamberlain’s cancer. In *Identified vs. Statistical Persons*, edited by I. G. Cohen, N. Daniels and N. Eyal. New York: Oxford University Press.

Frick, Johann. 2013. Uncertainty and Justifiability to Each Person. In *Measurement and Ethical Evaluation of Health Inequalities*, edited by N. Eyal, S. A. Hurst, O. Norheim and D. Wikler. New York: Oxford University Press.

Gakidou, E. E., C. J. Murray, and J. Frenk. 2000. Defining and measuring health inequality: an approach based on the distribution of health expectancy. *Bull World Health Organ* 78 (1):42-54.

Hausman, Dan M. 2007. What's Wrong with Health Inequalities? *Journal of Political Philosophy* 15 (1).

Hausman, Dan. M., and Matt Sensat Waldren. 2011. Egalitarianism Reconsidered. *Journal of Moral Philosophy* 8 (4):567-586.

Hausman, Daniel M. 2013. Egalitarian Critiques of Health Inequalities. In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, S. A. Hurst, O. F. Norheim and D. Wikler. New York: Oxford UP.

Institute of Medicine. 2002. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington DC.

International Society for Equity in Health (ISEqH). *2005 Working Definitions* 2005. Available from [www.iseqh.org/en/workdef.htm](http://www.iseqh.org/en/workdef.htm).

Lippert-Rasmussen, Kasper. 2004. Are Some Inequalities more Unequal than Others? Nature, Nurture and Equality. *Utilitas* 16 (2):193-219.

Repeated Author. 2013. When group measures of health should matter. In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, S. A. Hurst, O. F. Norheim and D. Wikler. New York: Oxford University Press.

Marmot, M. 2004. *The Status Syndrome; How Social Standing Affects Our Health and Longevity.* London: Bloomsbury Publishings.

Marmot, Michael. 2013a. Fair Society Healthy Lives. In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, S. A. Hurst, O. F. Norheim and D. Wikler. New York: Oxford University Press.

Marmot, Sir Michael. 2013b. Health inequalities in the EU: Final report of a consortium. European Commission Directorate-General for Health and Consumers.

Morgenstern, L. B., M. A. Smith, B. N. Sanchez, D. L. Brown, D. B. Zahuranec, N. Garcia, K. A. Kerber, L. E. Skolarus, W. J. Meurer, J. F. Burke, E. E. Adelman, J. Baek, and L. D. Lisabeth. 2013. Persistent Ischemic stroke disparities despite declining incidence in mexican americans. *Annals of neurology*.

Murray, C. J., E. E. Gakidou, and J. Frenk. 1999. Health inequalities and social group differences: what should we measure? *Bull World Health Organ* 77 (7):537-43.

Murray, CJL, SC Kulkarni, C Michaud, N Tomijima, MT Bulzacchelli, and et al. 2006. Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States. *PLoS Med* 3 (9):e260.

Norheim, Ole F. 2013. Atkinson’s index applied to health: can measures of economic inequality help us understand trade-offs in health care priority setting? In *Inequalities in Health: Concepts, Measures, and Ethics*, edited by N. Eyal, S. A. Hurst, O. F. Norheim and D. Wikler. New York: Oxford University Press.

Otsuka, Michael. 2011 draft. The Fairness of Equal Chances.

Pogge, Thomas. 2002. *Global Justice*. Oxford: Wiley-Blackwell

Powers, M., and R. Faden. 2008. *Social Justice: The Moral Foundations of Public Health and Health Policy*. New York: Oxford University Press.

Rae, Douglas. 1981. *Equalities*. Cambridge, MA: Harvard UP.

Roemer, John E. 2000. *Equality of Opportunity*. Cambridge, MA: Harvard University Press.

Sen, Amartya K. 1992. *Inequality Reexamined*. Oxford: Oxford University Press.

Singh, Gopal K. 2010. Child Mortality in the United States, 1935-2007: Large Racial and Socioeconomic Disparities Have Persisted Over Time. A 75th Anniversary Publication. In *Health Resources and Services Administration, Maternal and Child Health Bureau*. Rockville, Maryland: U.S. Department of Health and Human Services.

Temkin, Larry S. 1993a. *Inequality*. Oxford: Oxford UP.

Repeated Author. 2003b. Egalitarianism Defended. *Ethics* 113:764–782.

Townsend, P., N. Davidson, and M. Whitehead. 1992. *Inequalities in Health: The Black Report; The Health Divide.* London: Penguin.

Walzer, Michael. 1983. *Spheres of justice: a defense of pluralism and equality*. New York: Basic Books.

Whitehead, Margaret. 1992. The concepts and principles of equity in health. *Int J Health Serv* 22:429–445.

Wilkinson, Richard G. 2001. *Mind the Gap: Hierarchies, Health, and Human Evolution*. New Haven: Yale UP.

Wolff, Jonathan. 2001. Levelling Down. In *Challenges to Democracy: The PSA Yearbook 2000*, edited by K. Dowding, J. Hughes and H. Margetts: Macmillan.

Wolff, Jonathan, and Avner de-Shalit. 2007. *Disadvantage*. New York: Oxford University Press.

Woodward, A., and I. Kawachi. 2000. Why reduce health inequalities? *Journal of epidemiology and community health* 54 (12):923-9.

Young, Iris Marion. 2001. Equality of Whom? Social Groups and Judgments of Injustice. *Journal of Political Philosophy* 9 (1):1-18.

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2. See a review of epidemiologists’ definitions of inequity in ([Braveman 2006](#_ENREF_6)). [↑](#footnote-ref-2)
3. Some epidemiologists’ definitions mention only the social nature of the relevant grouping, without explicitly focusing on social status or social (dis)advantage. As an example, the *International Society for Equity in Health* defines equity in health as ‘the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population subgroups defined socially, economically, demographically, or geographically’ ([International Society for Equity in Health (ISEqH) 2005](#_ENREF_24)). No mention of hierarchy here. Likewise, Norman Daniels, who takes the epidemiologists’ side on all of this, endorses a focus on ‘health inequalities across social groups’—again, without mentioning that these social/demographic groups are marked out by differences in social advantage ([Daniels 2007, 21-22, and p. 79 identifies health inequality wwith 'an inequality in health status between different demographic groups'](#_ENREF_12)). Accordingly, one might distinguish between (1) s*tatus-group egalitarianism* (which we discuss above); (2) *social-group egalitarianism* (which examines inequality between social groups, not necessarily between status groups); and even (3) *group egalitarianism* (which examines inequality between groups, not necessarily social groups). But usually, omission to mention hierarchy and status in the definition is unintended. The focus on status groups is attested by the way the definition is applied (the only examples Daniels uses to illustrate his definition are status groups: ‘race or ethnic group, class, or gender’ ([Daniels 2007, 22, 79ff.](#_ENREF_12))), and by omission to correct other epidemiologists’ explicit concern with social (dis)advantage ([Braveman 2006, 167, 169](#_ENREF_6)). [↑](#footnote-ref-3)
4. Jonathan Wolff has used a somewhat parallel example to argue that social inequalities alone are important enough to justify leveling down ([Wolff 2001](#_ENREF_47)). [↑](#footnote-ref-4)
5. Earlier the authors clarify ‘(In this paper we are concerned primarily with inequalities that are attributable to social, economic and cultural causes’ ([Woodward and Kawachi 2000](#_ENREF_49)). [↑](#footnote-ref-5)
6. To substantiate the emphasis on inequalities that comes from individuals’ social positions, Iris Young cites Rawls’s priority for the basic structure of society ([Young 2001, 12](#_ENREF_50)). But what was Rawls’s argument for that priority? Primarily that the basic structure has pervasive and profound impact on people’s lives. Surely however health can have such pervasive and profound even when its causes are natural. Down syndrome that happens to result from sheer natural causes, no social structure involved, has profound and pervasive impact on the person. [↑](#footnote-ref-6)
7. Dan Hausman and Matt Waldren made a similar point regarding inequality between groups:

   Because individuals are not generally responsible for differences in welfare, resources, opportunities, or capabilities across religious, ethnic, or geographical groups, luck egalitarians will generally find differences among such groups to be *prima facie* injustices ([Hausman and Waldren 2011](#_ENREF_21)). [↑](#footnote-ref-7)
8. This dovetails with Iris Young’s clarification of her own position that when ‘Native Americans as a group have the lowest incomes, highest infant mortality rates, least education, and so on, of any group in American society, then we are entitled to say that members of this group probably suffer injustice’ ([Young 2001, 16](#_ENREF_50)). It also dovetails with Braveman’s point that ‘Whether or not a causal link exists, health disparities adversely affect groups who are already disadvantaged socially, putting them at further disadvantage with respect to their health, thereby making it potentially more difficult to overcome social disadvantage. This reinforcement or compounding of social disadvantage is what makes health disparities relevant to social justice even when knowledge of their causation is lacking’([Braveman et al. 2011, S151](#_ENREF_7)). [↑](#footnote-ref-8)