Redistribution and Recognition

Pursuing Social Justice in Public Health

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Rich people live longer and healthier lives than the poor. In the past several decades, researchers have gained increasing insight into the robust and persistent relationship between social position and health, a pattern referred to as the social gradient in health. This gradient, and the inequalities it represents, holds across all fourteen major causes of death and most forms of mental disorder, persists into the upper reaches of socioeconomic strata, and is foreshadowed by social inequalities in children's health and development.[1,2] Differences in health between advantaged and disadvantaged groups are significant and growing.[3,4,5] For many in public health, elucidating the causes of these health inequalities constitutes the field's signal problem; remedying them, its moral purpose.

Public action to eliminate health inequalities commonly is justified on grounds of social justice. The recent report from the World Health Organization's Commission on the Social Determinants of Health claims that "social injustice is killing people on a grand scale."[6] Against this backdrop of moral clarity, moral philosophers and bioethicists have begun to analyze the grounds on which health inequalities related to socioeconomic class and race/ethnicity might be deemed unjust and to articulate the goals of social justice in public health.[7,8,9,10] Considerable attention has been devoted to examining why health should be subject to principles of justice and to determining when health inequalities are unjust. Such analyses address the "distributive" demands of justice in their attempts to answer two questions that preoccupy modern conceptions of distributive justice: Which goods should be subject to justice? How much of them should everyone have?[11]

In this article, I examine a separate demand of justice that concerns the respect owed to socially disadvantaged groups and communities targeted by public health research and action for health promotion. Although some theories of justice incorporate respect for persons among their distributive goals or interpret distributive justice as an expression of equal respect,[12] critics question whether distributive theories can secure this nonmaterial good.[13,14,15,16] They argue that such theories neglect the social relations and institutional processes by which redistribution occurs and, in doing so, reproduce and reinforce the marginalized status of nondominant groups. Justice must, these critics contend, be concerned with not only distributing goods but also, and more fundamentally, ending relations of domination and establishing relations of equality.

This critique of distributive justice has particular salience for those engaged in the pursuit of a more equitable distribution of health. I explain why in the first section of the article, in which I show how redistributive policies to reduce health inequalities can reinforce nondominant groups' subordinate status, inflicting

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what political philosopher Nancy Fraser calls harms of "misrecognition." These harms, I argue, reveal a conflict between the distributive and the recognitional goals of justice. If this analysis is correct, it raises the question of how theories of social justice used to guide collective action to reduce health inequalities (a distributive goal) can also secure the respect and recognition owed to nondominant groups (a recognitional goal). I take up this question in the second section of the article, using Madison Powers and Ruth Faden's theory of social justice, which I interpret as establishing a norm of "equal recognition" that safeguards against misrecognition. But, I argue, this norm needs further specification in order to make explicit the terms of inclusion of nondominant groups in the project of health equity, which I refer to as a requirement for *participatory parity in health.* I examine the meaning of this more fully specified norm in the third section of the article and point to promising models and movements in public health that illustrate what participatory parity in health might look like on the ground.

Health Equity and Harms of Misrecognition

The elimination, indeed even the reduction, of health inequities poses a significant policy challenge. As many have observed, initiatives to improve population health often produce or reproduce existing inequities in health.[17] Health initiatives that rely on individual initiative and resources are the most likely to (re)produce health disparities because they leave intact entrenched socioeconomic inequalities. Take, for example, health education campaigns, which benefit individuals only when and if they become aware of and act on health-related information and are supported in changing their behavior. Similarly, biomedical advances typically benefit individuals only when and if they become aware of and have the resources to act on them by seeking medical advice and treatment.

In such cases, Link and Phelan explain, socioeconomic status functions as a "fundamental cause" of health inequalities, because resources such as money, knowledge, power, prestige, and social support work to the health advantage of better-off groups, even as risk and protective factors change dramatically from one historical period to the next.[18] Socioeconomic resources exert their influence in two ways. At the behavioral level, these resources influence "whether individuals are aware of, have access to, can afford, and are supported in their efforts to engage in health-enhancing behaviors."[19] At the contextual level, these resources influence "access to broad contexts such as neighborhoods, social networks, and occupations that vary in their associated profiles of risk and protective factors."[20] For example, wealthier neighborhoods are better protected from criminal activity and noise, and occupations that require higher levels of education are typically safer, more stable, and accompanied by benefits such as healthcare and paid time off, workplace flexibility, and autonomy.

Health Equity

Improving the health of disadvantaged groups, then, requires population-based policies and interventions that act on the contexts in which people grow up, live, work, and play. Such initiatives may improve social and environmental conditions for health (e.g., fluoridating water, establishing public smoking bans, and mandating air bags in automobile design and lead abatement in old housing stock). Or,

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policies may directly improve the socioeconomic status of vulnerable populations (e.g., Social Security and living wages). These initiatives seek to make health-beneficial resources and conditions more widely available to all groups and, when possible, unavoidable, such that health benefits are conferred to all, even in the absence of individual initiative and resources.[21]

Yet, even population-based interventions can (re)produce health inequities.[22,23] They, like their more individualistic counterparts, tend to benefit more advantaged groups first and disproportionately because better-off groups are better situated to benefit from improved conditions. And even when health initiatives do produce health gains among disadvantaged groups, as they often eventually do, these initiatives may increase relative disparities between better- and worse-off groups. Mechanic illustrates this phenomenon with the example of U.S. infant mortality. In 1950, black infant mortality was 64 percent higher than white infant mortality, with 43.9 deaths per thousand compared to a white rate of 26.8. By 1998 black infant mortality was 130 percent higher, with 13.8 deaths per thousand compared to a white rate of 6.0.[24] Both groups made significant absolute health gains, but whites gained more.

In response, policy leaders often recommend an additional strategy that targets the particular needs and circumstances of disadvantaged groups.[25] The goal is to tailor or "translate" population-based approaches into interventions that can better reach and impact disadvantaged groups.[26] Link and Phelan describe the strategy as "contextualizing risk and protective factors," such that the life circumstances and conditions that create barriers to behavioral change are eliminated.[27] As an example of such an approach, interventions to reduce obesity would reduce the cost of and increase the availability of healthy foods, reduce the oversaturation and excessive advertising of fast food outlets in disadvantaged neighborhoods, improve access to safe and convenient places to exercise, and so on. Targeted interventions take a variety of forms but typically involve robust outreach programs and the provision of services and resources. As already noted, these interventions are deemed essential to the pursuit of health equity. "Health promotion efforts that are not targeted at the poor are likely to *increase* [socioeconomic] disparities, because they are used more readily by those with more resources to act on the information."[28]

Harms of Misrecognition

The call to target disadvantaged groups seeks to correct what many (including this author) view as an injustice—deep inequalities in health and the social determinants thereof. Yet, targeting disadvantaged groups risks inflicting an injustice of another sort—what political philosopher Nancy Fraser calls "misrecognition."[29] Fraser describes misrecognition as a form of disrespect expressed by "institutionalized patterns of cultural value" that create relations of subordination. Subordinated groups are treated as "inferior, excluded, wholly other, or simply invisible"[30] and may be subject to shaming, demeaning stereotypes, harassment, assault and violence, and exclusion from deliberative forums and participation in public life.[31] Misrecognition constitutes an injustice, Fraser argues, because it denies people the opportunity to interact and to engage as peers in social life.

My claim is not that agents of public health intend such harms. Rather, it is that the policy and practice of targeting disadvantaged groups takes place within and

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is itself a part of a broader context of social relations and institutional processes that subordinate nondominant groups either by (1) heightening conceptions of them as deviant, thus denying their common humanity, or (2) imposing on them expectations of assimilation, thus denying their distinctive life experiences, traditions, and histories.[32] Targeted policies risk reinforcing views of nondominant groups as deviant in two respects. The first relates to the meaning and value of health. Health in the modern era is seen as an achievement—"something people are supposed to work at."[33] Add to this the fact that poor health habits and attributes such as smoking and obesity are stigmatized and despised. Against the backdrop of these social norms, disadvantaged groups' disproportionate incidence of poor health and unhealthy behaviors subjects them not only to (well-intended) targeting but also to scrutiny, blame, and disapproval. The ethical risk is that health will be viewed as just one more thing that "these people" have failed to achieve.

The second way in which the perception of deviance may be reinforced relates to the provision of additional resources and services. Targeted resources and services subject these groups to public resentment and hostility. The public provision of targeted resources, like any form of welfare, risks casting recipients as helpless or as "scroungers."[34] Moreover, the provision of resources and services, particularly when state funded, often also subjects these groups to demeaning intrusions into or the elimination of personal choices. Current policy debates over whether to prohibit welfare recipients from using food stamps to purchase soda (in an effort to reduce obesity in this population) are a case in point.[35]

A second form of misrecognition occurs when dominant groups impose their values and expectations on nondominant groups. The most basic illustration of this is that health initiatives assume the preeminence of health as a value and a priority. Yet, health may or may not figure prominently among these groups' values. This incongruity is suggested, for example, in studies of smoking, which indicate that for some groups of men it plays an important role in reinforcing ideals of masculinity.[36] Other examples easily come to mind: culinary traditions may carry important cultural meaning that trumps health risks, corpulent body images may signal health and abundance, long work hours and unpaid domestic responsibilities may preclude relaxation and exercise, and so on. Health initiatives may serve and be experienced as tools of assimilation rather than as (welcomed) opportunities to improve their health.

Misrecognition in the form of ascribed similarity also can occur when researchers assume alignment between their and the targeted population's assessments of barriers to health. Yet, researchers' interpretations of barriers often differ from those of the targeted group.[37] A study examining barriers to physical activity, for example, in which researchers hypothesized the salience of recreational facilities found instead that low-income urban women ranked physical security, street and sidewalk lighting and cleanliness, and gang violence as more important.[38] Health research that fails to investigate and learn how community members view the problem fails to acknowledge their lived experience, renders them silent, and, in doing so, risks overlooking the real barriers to health.

The upshot is that such research actually may perpetuate health inequalities through the following chain of likely events. Interventions that fail to remedy barriers to health relevant to targeted groups are unlikely to yield improvements in their health. When public investments to improve the health of vulnerable

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groups repeatedly fail, the results are, for reasons already described, likely to be blamed on poor people, not poor research and intervention design. This result reinforces the view that poor health and bad habits are the province of the poor and mark the disadvantaged as "inherently deficient . . . always needing more and more."[39] This perception can entrench or exacerbate stigmatization, discrimination, and social exclusion of these groups, all of which contribute to health disparities.[40]

This is not an argument against the pursuit of health equity. It is an illustration of critics' concerns, noted in the introduction, that the pursuit of a fair distribution of goods may instead demean, marginalize, and oppress nondominant groups. It also raises a question about how a theory of social justice might guide the pursuit of a more equitable distribution of health (a distributive goal) while also securing the respect owed to minority and marginalized communities and groups (a recognitional goal). In the next section, I use Madison Powers and Ruth Faden's theory of social justice, one of the best ethical resources currently available to agents of health equity, to examine the question.

Redistribution and Recognition in Public Health

Powers and Faden's account of social justice is especially well suited for this investigation. Although theirs is a general theory of social justice, they take particular interest in its application to the health arena and to health inequalities. They argue that the moral foundation of public health is social justice, not a general obligation of beneficence to promote human health as is often (implicitly) assumed.[41] Their account seeks to secure for all persons a sufficient level of the essential dimensions of well-being, which they identify as health, personal security, reasoning, respect, attachment, and self-determination.[42] In addition, their criteria for determining what constitutes a "sufficient" level of well-being depend in an important way on whether social groups are subject to oppression and subordination. They characterize oppression and subordination as forms of domination that generate "systematic patterns of disadvantage," which act as structural barriers to human well-being. Thus, they argue, social groups subject to systematic patterns of disadvantage are likely to suffer insufficiencies in well-being.[43]

But perhaps what makes their theory most apt for the current investigation is its view of justice as "an inherently remedial task," one that that must be responsive to constantly changing impediments to human well-being. "In a nonideal world, questions of justice emerge from the operation of the totality of social institutions, practices, and policies that both independently and in combination have the potential for profound and pervasive impact on human well-being."[44] Together these commitments suggest a theory that demands vigilant attention to shifting dynamics, *including unanticipated ones*, such as the possibility that (otherwise laudable) public health policies to remedy health inequities might instead reinforce the marginalized status of nondominant groups and perpetuate health inequities.

What resources does their theory possess to protect against such harms? The most important resource is their account of respect, one of the six essential dimensions of well-being that justice must secure. Powers and Faden designate respect as an explicit goal of justice, define it in terms that would identify misrecognition (as I have described it) as an injustice, and attribute special moral status to it. Respect

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refers to the requirement to see others as a source of equal moral worth and to understand oneself as the moral equal of others. They refer to this as "recognition respect."[45] Recognition respect is flouted when people are oppressed or discriminated against on the basis of their skin color, gender, sexual orientation, class, and so on.[46] To clarify the meaning of recognition respect, they distinguish it from appraisal respect, which refers to respect based on personal and social merit and achievement. In contrast, recognition respect "is owed to each of us as agents entitled to treatment worthy of members of the moral community."[47] The special status of recognition respect is built into Powers and Faden's interpretation of what constitutes a sufficient level of it. Respect on their view is so essential to human flourishing that sufficiency in its case demands equality. For health and other dimensions, inequalities may be permissible. But, "respect has its value for any individual or group of individuals only when the social conditions that promote and sustain it are equal for all."[48]

The special moral status of recognition respect suggests, then, that in cases in which public health activity to improve the health of disadvantaged groups is suspected or shown to reinforce their subordination, presumably such activity would be deemed ethically impermissible. Powers and Faden themselves suggest this, saying that at the very least justice requires that "public health policies do not exacerbate [systematic disadvantage]."[49] They illustrate this commitment when describing their own ethical assessment of a program that targeted poor pregnant women with HIV for treatment, which they and their colleagues rejected as morally impermissible because it would have heightened the disrespect and stigma these women suffered. They refer to such concerns as "nondistributional" considerations of justice,[50] a description that supports some theorists' contention that the recognitional goals of justice must be separate from the distributive goals or must somehow otherwise be distinguished within a theory of justice.[51,52]

If my interpretation of their account of recognition respect is correct, their theory provides considerable protection against harms of misrecognition. In effect, it establishes a norm of *equal recognition* that places ethical limits on the pursuit of health promotion and the reduction of health disparities. When collective action to achieve a fairer distribution of health and the social determinants thereof jeopardizes equal recognition, it would be deemed morally suspect if not impermissible. This interpretation raises a theoretical question of whether the essential dimensions of well-being are, in effect, lexically ordered, with priority assigned to recognition respect. This is not how Powers and Faden depict the matter. Yet, it is a plausible interpretation that seems compatible with the centrality accorded in their theory to ending relations of domination and oppression and securing equal respect for all persons.

For all of the protection their theory provides against harms of misrecognition (at least as I have interpreted it), I believe their account of equal recognition could be strengthened. The demand for equal recognition tells us that public health research and policy should be evaluated for potential harms of misrecognition. It tells us nothing about *who* should be involved in that evaluative process. In the absence of such guidance, the task is likely to be carried out by experts in the science and ethics of public health. Such experts may be vigilant and attentive in their moral assessments of proposed research and policy.[53] They also may be well positioned to discredit harmful policies and stop them from being implemented.

But experts should not be the only participants in this process. The voices of the groups and communities targeted by research and action must also be included, because, as I have argued previously, leaving them out risks inflicting

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harms of misrecognition and perpetuating health disparities. Powers and Faden seem to agree up to a point: they say that the "voices and perspectives of those whose life experiences reflect the cumulative weight of multiple disadvantages" should be heard, but only when working out their theory's implications in "concrete situations."[54] I would suggest, on the contrary, that those voices must be incorporated into the bedrock of any theory of justice fundamentally concerned with ending relations of domination and establishing relations of equality. One way to do this is to expand the meaning and requirements of equal recognition. Drawing on ideas advanced by political philosophers such as Fraser and Elizabeth Anderson, I propose that the norm of equal recognition be expanded to include the norm of participatory parity, which I frame in the following as a requirement for participatory parity in health.

Equal Recognition and Participatory Parity in Health

According to Fraser the goal of participatory parity is to ensure that all (adult) members of society can interact with one another as equal peers in public life. Participatory parity aims to preclude systematic discrimination, stigmatization, and social exclusion and to promote respectful interaction, reciprocal engagement, and equal opportunity for participation in social life.[55] Similarly, Anderson prescribes a social order in which persons "stand in relations of equality," where all are entitled to participate and to be heard and others have an obligation to listen and respond respectfully.[56]

The Norm of Participatory Parity in Health

These commitments inform the norm of participatory parity in health in two ways. First, participatory parity in health has *democratic* intentions. It is concerned with the voices and decisionmaking power of nondominant groups. To that end, it requires the institutionalization of policies and practices that create opportunities for members of nondominant groups to participate in a meaningful way in the processes of public health research and action. Members of these communities are to be seen as *agents*, not simply recipients, of public health action. As agents, they have the potential to act as and be seen as effective, deliberative, and creative resources for social change, not simply victims or sources of pathology.[57]

Second, participatory parity in health has *transformative* intentions. Transformative action seeks to remake the underlying social structures and processes that generate harms.[58] As I have shown, those structures and processes should include the standard policy of targeting disadvantaged groups for health promotion. Transformed policy and practices would require that these targeted groups be involved upstream, engaged not only in evaluating already-formulated interventions for their appropriateness, acceptability, and potential harms but also in designing research and interventions.[59] Members of these communities are to be seen as *peers* in the health equity enterprise. As peers, they are engaged in the formulation of the goals of public health research and policy.

The Practice of Participatory Parity in Health

Participation in health is not a novel idea, and in some places and by some measures participation has been institutionalized as a norm and a practice in

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health and development contexts. The 1978 Declaration of Alma-Alta, sponsored by the World Health Organization, formalized the idea of participation as a "right and duty" of the people to be involved in planning and addressing their health needs.[60] Nongovernment organizations working in developing countries, the World Bank, and many others heartily endorse community participation in health.[61] The 2008 report from WHO's Commission on the Social Determinants of Health includes participation as an essential element of health equity.[62]

In the United States, the American Public Health Association's Code of Ethics includes a provision to work for the empowerment of disenfranchised groups.[63] A review of moral considerations integral to U.S. public health includes public participation as a requirement of procedural justice.[64] In addition, interest in community-based participation in health research has been growing markedly over the last 15 years. Philanthropies and the government via the Centers for Disease Control and the National Institutes of Health have created training and grant programs to support community-based participatory research (CBPR).[65] A 2002 Institute of Medicine study included CBPR among eight new areas of training that public health professionals should receive.[66]

There is no question that participation in health has widespread appeal and acceptance as a principle of public health research and action. But whether such declarations, programs, and activities embody a commitment to participatory parity in health is a separate question, the answer to which turns on how participation is defined and what it looks like on the ground. The term "participation" is used in a variety of ways, not all of which capture the democratic or transformative intentions of participatory parity. Morgan describes a "definitional divide" that distinguishes between participation as a means to achieve project goals efficiently and effectively and participation as an end to empower the community to define the problem and create a locally controlled process to address it.[67] The former adopts a utilitarian perspective wherein improved efficiency and effectiveness may be achieved via community collaboration with programs that are developed externally; the latter adopts an empowerment perspective focused on people-centered community development and social change.

Efficiency and effectiveness are important values in public policy and should always be welcomed. But participatory parity in health is about agency and shared power. It expresses a deep belief in people's ability to assess their strengths and needs, express their views, set priorities, and act on them.[68] An example of what participatory parity might look like in action took place in Bolivar County, Mississippi, during the late 1960s and 1970s against the backdrop of the civil rights movement and the U.S. war on poverty. The Tufts-Delta Health Center explicitly sought to be "an instrument of community development and social change."[69] In addition to medical and health education services and environmental programs to improve sanitation, water supplies, and housing, the Tufts-Delta Health Center had a community empowerment program that, through the creation of local health associations and the North Bolivar County Health Council, addressed financing and mortgages, education, transportation, and nutrition. The community identified these needs and in many cases ran the programs.

The Tufts-Delta Health Center approach was modeled on a pioneering South African program that invested in training, educating, and employing local residents and in these ways (among others) acted on the social determinants of health.[70] Other examples abroad include the Comprehensive Rural Health Project

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in India, which served as an inspiration for the 1978 International Conference on Primary Care at Alma Alta, out of which came the declaration noted previously.[71] Unfortunately, in the United States, community health centers, of which Tufts-Delta was a groundbreaking model, have in the last three decades largely retreated to providing more traditional medical and public health services,[72] although exceptions exist.[73] The movement toward CBPR in U.S. public health research, however, reflects many of these same commitments, stressing collaboration with community members, equitable involvement in and shared control over all phases of research, mutual learning among partners, local capacity building, and social change.[74,75]

These examples illustrate what participatory parity in health might look like in practice. No doubt, other possibilities exist. Participatory parity might look different in different communities and for different sorts of health problems and opportunities. The task of figuring out what sort of practices might fulfill this normative standard will need to be worked out through continued experimentation with participatory processes and dialogue and debate. This experimentation and debate will need to address other complex challenges, such as determining *who* exactly should be involved in participatory processes. I have not addressed very difficult questions about who represents any particular disadvantaged group. Such complexities do not, in my view, undermine the norm of participatory parity. Rather they simply demonstrate that the norm requires further elaboration, clarification, and specification. Much work lies ahead for theorists, practitioners, and the communities with whom they work.

Conclusion

In this article I have argued that the pursuit of a fair distribution of goods, in this case health and the social determinants thereof, must be constrained by a demand for equal recognition. Social justice requires it. To that end, I have argued for an account of equal recognition that makes explicit the terms of inclusion of non-dominant groups in the project of health equity. This norm of participatory parity in health creates an obligation to engage communities and groups in discussion and deliberation about the goals of public health research and policy and to involve them in the work itself.

This call for participatory parity may be subject to any number of objections. Some may object that a requirement for participatory parity in health places an unrealistic demand on agents of public health, perhaps noting challenges related to funding structures or reward structures within academic institutions. Others may object on the grounds that not all health challenges lend themselves to community participation. A very different sort of objection may issue from agents of public health who may wonder why an ethical argument for community participation needs to be made at all, because (as I have pointed out) community participation has long been viewed as a principle of public health and development action.

To the first category of critics, I would suggest that funding and reward structures need to be realigned so as to support participation and that clarifying and specifying the moral grounds for participation can help make the case for such change. To those who suggest that participation may be inappropriate under some circumstances, I would acknowledge the point. It might be that the

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urgent or lethal nature of some health threats precludes participatory parity. Still, it is worth noting that robust participatory methods sometimes can be done in advance, as a part of planning for health threats, as has been case for pandemic flu planning. To the last category of critics I would say that although community participation has long been acknowledged as principle and value of public health and development, it has not always been enacted or enacted in a way that demonstrates equal respect for those groups subject to targeting. As others have noted, attempts to engage the community may be carried out in ways that alienate and breed distrust among nondominant groups.[76]

Indeed, such examples underscore the importance of being very clear about why it is a moral imperative to engage disadvantaged groups in the broader project of health promotion and health equity. Participatory parity is necessary not only because it may improve the efficacy of health interventions for disadvantaged groups. Participatory parity can also begin to alter in a fundamental way how these groups are to be seen and treated—not as an undifferentiated "aggregation of the sick or potentially sick"[77] or as a "population" on which to act.[78] Rather, they should be seen as agents of change and peers in the health equity project. Their insights and stories must be heard if we are to make progress on social justice together.

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