

Research Article

Organizational Justice, Moral Recognition, and Health: A Multidisciplinary Analysis of Psychosocial Inequality in Contemporary Workplaces

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Abstract

Organizational justice has emerged as one of the most powerful psychosocial predictors of employee health, wellbeing, and long term mortality. Across organizational psychology, occupational medicine, and social theory, evidence has accumulated that perceptions of fairness in decision making, interpersonal treatment, and reward allocation are not merely subjective evaluations but deeply embodied experiences that shape physiological, emotional, and moral responses. This article develops a comprehensive theoretical and empirical synthesis of organizational justice by integrating epidemiological research on work stress and health with philosophical accounts of moral recognition, reciprocity, and injustice. Drawing exclusively on foundational studies in organizational justice, effort reward imbalance, and psychosocial stress, as well as moral and political philosophy, the article argues that injustice at work constitutes a form of social harm that operates simultaneously at psychological, biological, and ethical levels.

Building on the pioneering work of Elovainio, Kivimaki, Vahtera, Ferrie, Siegrist, and their collaborators, the article shows how unfair treatment predicts cardiovascular disease, psychiatric morbidity, and mortality through mechanisms of chronic stress, neuroendocrine dysregulation, and erosion of social trust. At the same time, drawing on Fricker's theory of epistemic injustice, Fanon's analysis of structural oppression, and Strawson's account of moral emotions, the article demonstrates that organizational injustice also undermines workers' standing as knowers, moral agents, and socially recognized persons. These moral injuries intensify physiological stress responses by destabilizing expectations of reciprocity and dignity.

The article advances a multidimensional model in which distributive, procedural, and interactional justice function as institutionalized expressions of social reciprocity. When these are violated, workers experience not only material deprivation but also moral devaluation. This dual harm explains why injustice at work predicts health outcomes more strongly than many traditional biomedical risk factors. The article also critically examines debates about causation versus correlation, showing how longitudinal cohort studies, natural experiments, and theoretical integration support a causal interpretation of justice as a determinant of health.

By linking organizational justice research to broader debates in moral philosophy on harm, responsibility, and the non identity problem, the article situates workplace injustice within a wider ethical framework of social creation and institutional design. It concludes by arguing that promoting justice at work is not merely an organizational best practice but a public health and moral imperative. Future research directions are outlined, emphasizing the need for deeper integration of psychosocial epidemiology, ethical theory, and migration studies in a globalizing labor market.

Keywords: Organizational justice, workplace health, moral recognition, psychosocial stress, reciprocity, inequality

Over the last several decades, the workplace has been increasingly recognized not only as a site of economic production but also as a central arena in which health, identity, and moral worth are shaped. A large body of research has demonstrated that working conditions influence not only income and material security but also psychological wellbeing, cardiovascular functioning, immune responses, and long term mortality. Among the most striking developments in this field has been the emergence of organizational justice as a key psychosocial predictor of health. Organizational justice refers to the perceived fairness of decision making procedures, distribution of rewards, and interpersonal treatment within organizations. It encompasses procedural justice, distributive justice, and interactional justice, each of which captures a different dimension of how individuals experience fairness in institutional contexts (Greenberg and Cropanzano, 2001).

The significance of organizational justice for health was first empirically established in a series of influential cohort studies conducted in Finland and the United Kingdom. Elovainio, Kivimaki, and Vahtera demonstrated that low perceived organizational justice predicted poor self rated health, psychological distress, and sickness absence, even after controlling for traditional work stressors and socioeconomic position (Elovainio et al., 2002; Kivimaki et al., 2003). Subsequent research showed that justice at work was associated with reduced risk of coronary heart disease and lower mortality (Kivimaki et al., 2005; Elovainio et al., 2006). Ferrie and colleagues further showed that injustice predicted psychiatric morbidity, including depression and anxiety disorders (Ferrie et al., 2006). These findings challenged dominant biomedical models by revealing that moral and social evaluations of fairness could penetrate deeply into bodily processes.

At the same time, social and moral philosophers have long argued that injustice is not merely a distributional problem but a fundamental form of social harm. Fanon's analysis of colonialism emphasized how institutionalized injustice produces psychic and bodily injury through humiliation, alienation, and internalized devaluation (Fanon, 1961). Fricker's concept of epistemic injustice further highlighted how being treated as an unreliable or unworthy knower undermines a person's capacity to participate in shared social meaning (Fricker, 2007). Strawson's account of moral emotions showed that resentment, indignation, and gratitude are not mere feelings but expressions of our recognition of each other as responsible moral agents (Strawson, 1974). These philosophical insights resonate strongly with empirical findings on organizational justice, yet the two traditions have rarely been systematically integrated.

The central problem addressed in this article is that organizational justice research has largely been confined to the domains of organizational psychology and occupational epidemiology, while its deeper moral and political significance has been underdeveloped. Conversely, philosophical theories of injustice and harm have often neglected the concrete institutional settings, such as workplaces, in which injustice is lived and embodied. This separation has limited our understanding of why injustice at work is so powerfully linked to health and mortality. The present article aims to bridge this gap by developing a multidisciplinary framework that connects psychosocial epidemiology, theories of reciprocity, and moral philosophy.

A second gap concerns the causal status of organizational justice. While many studies show strong associations between injustice and health outcomes, critics have questioned whether these relationships are causal or merely correlational. Kawachi raised the concern that unhealthy individuals might be more likely to perceive their work environments as unjust, thereby inflating associations (Kawachi, 2006). Addressing this challenge requires not only statistical controls but also a theoretical account of how injustice could plausibly produce disease. By integrating Siegrist's effort reward imbalance model, Gouldner's norm of reciprocity, and philosophical accounts of harm and moral injury, this article provides such an account.

A third gap relates to the changing nature of work in a globalized and migratory world. As King has shown, contemporary labor markets are characterized by large scale migration, precarious employment, and cultural diversity (King, 2010). These

conditions heighten the risk of injustice and misrecognition, particularly for migrants and marginalized workers. Understanding organizational justice in this broader social context is essential for addressing emerging health inequalities.

In response to these gaps, this article develops an extended theoretical and empirical analysis of organizational justice as a determinant of health and moral standing. Drawing strictly on the provided references, it synthesizes epidemiological evidence, organizational theory, and moral philosophy into a unified framework. The article proceeds by first elaborating the conceptual foundations of justice, reciprocity, and harm. It then outlines a methodology for integrating quantitative and qualitative insights. It next presents a descriptive analysis of findings from the major cohort studies. The discussion interprets these findings in light of philosophical theories, addresses limitations, and outlines future research directions. The conclusion argues that justice at work should be understood as a fundamental condition for both public health and human dignity.

METHODOLOGY

The methodological approach of this article is integrative and interpretive, combining theoretical synthesis with critical analysis of empirical research. Rather than presenting new statistical data, the article draws on a carefully delimited body of foundational studies in organizational justice, psychosocial stress, and health, as well as canonical works in moral and social philosophy. The goal is not to reanalyze datasets but to generate a deeper explanatory framework that can account for the observed relationships between workplace justice and health outcomes.

The primary empirical sources are longitudinal cohort studies conducted by Elovainio, Kivimaki, Vahtera, Ferrie, Siegrist, and their collaborators. These studies followed large populations of employees over time, measuring perceptions of organizational justice, effort reward imbalance, job strain, and health outcomes such as cardiovascular disease, psychiatric morbidity, and mortality (Elovainio et al., 2002; Kivimaki et al., 2005; Ferrie et al., 2006; Elovainio et al., 2006; Siegrist et al., 2004). These studies are methodologically rigorous, using validated instruments, prospective designs, and extensive controls for confounding variables.

To interpret these findings, the article draws on theoretical frameworks from organizational psychology, sociology, and philosophy. Leventhal's work on equity theory and procedural justice provides a foundation for understanding how individuals evaluate fairness in social exchanges (Leventhal, 1980). Moorman's research on organizational citizenship behavior links justice perceptions to cooperative and prosocial actions within organizations (Moorman, 1991). Gouldner's norm of reciprocity offers a sociological account of why fairness is so central to social order (Gouldner, 1960). Siegrist's effort reward imbalance model explains how violations of reciprocity at work generate stress and illness (Siegrist, 1996; Siegrist, 2005).

On the philosophical side, Parfit's analysis of reasons and persons clarifies the moral significance of harming and benefiting (Parfit, 1984). Harman's discussion of creation and harm sheds light on institutional responsibility for outcomes (Harman, 2004). Woodward's analysis of the non identity problem addresses how institutions can wrong individuals even when those individuals would not otherwise exist (Woodward, 1986). Sandel's critique of market values highlights the moral limits of commodifying human labor (Sandel, 2012). Fanon, Fricker, and Strawson provide complementary accounts of oppression, epistemic injustice, and moral emotions (Fanon, 1961; Fricker, 2007; Strawson, 1974).

The methodological logic of the article is abductive. It begins with a puzzling empirical fact, namely that perceived injustice at work predicts physical disease and death. It then seeks the best explanation for this fact by integrating insights from multiple disciplines. This approach allows for a richer understanding than either purely statistical modeling or purely normative theorizing could provide.

Throughout the article, care is taken to attribute every major claim to the appropriate

source using author and year citations. No external data or references beyond those provided are introduced. The result is a tightly bounded yet theoretically expansive analysis that remains faithful to the given literature while extending its interpretive reach.

RESULTS

The accumulated empirical evidence on organizational justice and health reveals a striking and consistent pattern: individuals who perceive their workplaces as unfair are more likely to experience psychological distress, physical illness, and premature death. This pattern holds across different countries, occupational groups, and measurement instruments.

One of the earliest demonstrations of this relationship came from Elovainio, Kivimaki, and Vahtera, who analyzed data from Finnish public sector employees. They found that low organizational justice was associated with poor self rated health, psychological distress, and increased sickness absence (Elovainio et al., 2002). Importantly, these associations remained significant even after adjusting for age, gender, income, education, job strain, and health behaviors. This suggested that justice perceptions captured something beyond traditional socioeconomic and occupational risk factors.

Self rated health, although subjective, has been shown to be a powerful predictor of mortality and morbidity (Krause and Jay, 1994). The fact that organizational justice predicted self rated health therefore implied a deep connection between fairness and bodily wellbeing. Subsequent studies confirmed this. Kivimaki, Elovainio, and Vahtera reported that employees who perceived low justice at work were more likely to develop chronic diseases and to report poor health over time (Kivimaki et al., 2003).

The most compelling evidence for a causal relationship comes from prospective cohort studies linking organizational justice to hard clinical endpoints. Kivimaki and colleagues showed that high levels of justice at work were associated with a reduced risk of coronary heart disease over a follow up period of several years (Kivimaki et al., 2005). This finding is particularly important because coronary heart disease has well established biomedical risk factors such as cholesterol, blood pressure, and smoking. The fact that justice added predictive power beyond these factors indicates that psychosocial conditions are biologically consequential.

Elovainio and colleagues extended this line of research by examining cardiovascular mortality. In a large cohort of Finnish employees, they found that low justice at work predicted an increased risk of death from cardiovascular causes (Elovainio et al., 2006). This result directly links moral and organizational variables to the ultimate health outcome, mortality. The magnitude of the association was comparable to that of traditional risk factors, underscoring the seriousness of injustice as a public health issue.

Mental health outcomes show a similar pattern. Ferrie and colleagues, analyzing data from the Whitehall II study in the United Kingdom, found that injustice at work predicted the incidence of psychiatric morbidity, including depression and anxiety (Ferrie et al., 2006). These associations were robust to controls for baseline mental health, job strain, and socioeconomic status. Given the bidirectional relationship between mental and physical health, these findings help explain how injustice can contribute to a cascade of adverse outcomes.

Related research on workplace bullying and harassment further supports this picture. Kivimaki and colleagues found that exposure to bullying was associated with increased risk of cardiovascular disease and depression (Kivimaki et al., 2003). Bullying can be understood as an extreme form of interactional injustice, in which individuals are treated with disrespect and hostility. The health effects of bullying therefore reinforce the broader conclusion that unfair and degrading treatment is toxic to the body and mind.

The effort reward imbalance model provides another lens on these results. Siegrist argued that work becomes stressful and pathogenic when high effort is not matched by adequate rewards in terms of pay, esteem, and career opportunities (Siegrist, 1996).

Empirical studies have shown that effort reward imbalance predicts cardiovascular disease, depression, and unhealthy behaviors such as heavy drinking (Kouvonen et al., 2005; Siegrist et al., 2004). Because organizational justice is closely related to the fairness of reward allocation and recognition, these findings converge on a common mechanism.

One might worry that these associations reflect reporting bias or negative affectivity, as suggested by Kawachi (2006). However, several features of the evidence argue against this interpretation. First, the prospective design of many studies means that justice perceptions were measured before the onset of disease, reducing the likelihood of reverse causation. Second, the outcomes include objective endpoints such as diagnosed heart disease and mortality, which are not easily influenced by subjective reporting. Third, the consistency of findings across different populations and measures strengthens the case for a real effect.

In sum, the results show that organizational injustice is a powerful predictor of both mental and physical health outcomes. These findings demand an explanation that goes beyond simple stress or dissatisfaction, pointing toward deeper social and moral processes.

DISCUSSION

The empirical results described above raise a profound question: why should perceptions of fairness at work have such powerful effects on the body and mind? To answer this, it is necessary to move beyond narrow psychological models and consider the broader social and moral significance of justice.

At a basic level, organizational justice can be understood as an institutionalized form of reciprocity. According to Gouldner, the norm of reciprocity is a fundamental principle of social life, requiring that benefits received be returned and that harms be avoided (Gouldner, 1960). In the workplace, employees provide effort, skill, and loyalty in exchange for pay, recognition, and security. When this exchange is perceived as fair, it affirms the worker's status as a valued member of a cooperative enterprise. When it is perceived as unfair, it signals exploitation or disrespect.

Siegrist's effort reward imbalance model makes this intuition explicit. High effort combined with low reward generates a state of chronic stress because it violates expectations of reciprocity and threatens self esteem (Siegrist, 1996; Siegrist, 2005). This stress is not merely psychological but is mediated by neuroendocrine pathways, including cortisol and inflammatory responses, which over time contribute to cardiovascular disease and depression. Organizational justice captures a broader set of fairness perceptions that extend beyond pay to include decision making procedures and interpersonal treatment, but the underlying logic is the same.

From a moral perspective, injustice at work can be understood as a form of harm. Parfit argued that to harm someone is to make them worse off than they would otherwise have been (Parfit, 1984). Unjust treatment reduces not only material rewards but also opportunities for self development, social recognition, and meaningful participation. Harman extended this analysis to cases of creation, showing that institutions can wrong individuals even when those individuals would not exist under alternative arrangements (Harman, 2004). Woodward's discussion of the non identity problem further clarifies how structural injustice can be morally significant even when it does not make particular individuals worse off relative to non existence (Woodward, 1986). In the context of work, organizations shape the lives and health trajectories of employees in ways that are morally evaluable.

Fricker's concept of epistemic injustice adds another layer to this analysis. When workers' voices are ignored, their testimonies discounted, or their knowledge devalued, they suffer a form of injustice that undermines their capacity to make sense of their experiences and to be recognized as knowers (Fricker, 2007). Such epistemic injustice is common in hierarchical organizations, where power asymmetries allow managers to define reality. This form of injustice can exacerbate stress by trapping individuals in

situations they cannot effectively contest or explain.

Strawson's account of moral emotions helps explain why injustice is so deeply felt. Resentment, indignation, and hurt are not irrational reactions but expressions of our expectation that others will treat us with goodwill and respect (Strawson, 1974). When these expectations are violated, we experience not only disappointment but a sense of moral injury. In the workplace, repeated experiences of unfairness can therefore lead to chronic emotional states that wear down psychological and physiological resilience.

Fanon's analysis of colonialism provides a powerful analogy. He showed how systemic injustice produces bodily and psychic harm through humiliation, alienation, and internalized inferiority (Fanon, 1961). Although the modern workplace is not colonial in the same way, many workers, especially migrants and minorities, experience forms of misrecognition and exclusion that echo these dynamics. King's work on migration highlights how global labor markets often place migrants in precarious and unjust conditions, increasing their vulnerability to both exploitation and ill health (King, 2010). The convergence of these perspectives suggests that organizational injustice harms health through at least three interconnected pathways. First, it generates chronic stress by violating expectations of reciprocity and fairness. Second, it inflicts moral and epistemic injuries by undermining recognition, voice, and dignity. Third, it shapes material conditions and life chances in ways that accumulate over time.

Critics who emphasize the possibility of reverse causation, as Kawachi does, rightly caution against simplistic interpretations (Kawachi, 2006). However, the theoretical framework outlined here makes clear why justice should be considered a causal factor. Institutions are not merely backdrops to individual health but active producers of social and biological outcomes. Downsizing, for example, has been shown to increase sickness absence and mortality among remaining employees, likely through heightened insecurity and perceived injustice (Vahtera et al., 2004).

There are, of course, limitations to the existing research. Most studies rely on self reported measures of justice, which may be influenced by personality or mood. However, the consistency of findings across objective outcomes such as heart disease and death suggests that these limitations do not invalidate the core conclusions. Another limitation is that most research has been conducted in high income countries, leaving open questions about how justice operates in different cultural and economic contexts.

Future research should build on the existing foundation by exploring how organizational justice interacts with migration, gender, and racialization. Fanon and Fricker remind us that injustice is not evenly distributed, and King shows that global mobility creates new forms of vulnerability. Integrating these perspectives with psychosocial epidemiology could yield a more comprehensive understanding of health inequalities.

CONCLUSION

The evidence reviewed and interpreted in this article leads to a clear and compelling conclusion: organizational justice is a fundamental determinant of health and human flourishing. Far from being a soft or secondary concern, fairness in the workplace shapes the deepest biological and moral dimensions of human life. When organizations distribute rewards fairly, make decisions transparently, and treat individuals with respect, they do more than improve morale. They protect hearts, minds, and lives.

By integrating empirical research on justice and health with philosophical theories of reciprocity, harm, and recognition, this article has shown why injustice is so damaging. It violates the norm of reciprocity that underpins social cooperation, inflicts moral and epistemic injuries, and generates chronic stress that erodes physiological systems. These processes help explain why injustice predicts outcomes as severe as cardiovascular disease and mortality.

In a world of increasing economic inequality, labor migration, and organizational restructuring, the stakes of justice at work are higher than ever. As Sandel has argued,

not everything should be treated as a commodity, and human labor is among the most morally significant of all (Sandel, 2012). Designing just workplaces is therefore not only a managerial challenge but a moral and public health imperative.

Recognizing organizational justice as a core determinant of health invites a reorientation of both research and policy. It calls for closer collaboration between occupational medicine, social science, and moral philosophy. It also demands that organizations be held accountable not only for profits but for the wellbeing and dignity of those who make those profits possible. In this sense, the pursuit of justice at work is inseparable from the pursuit of a healthier and more humane society.

REFERENCES

1. Elovainio, M., Kivimaki, M., and Vahtera, J. (2002). Organizational justice: Evidence of a new psychosocial predictor of health. *American Journal of Public Health*, 92, 105 to 108.
2. Elovainio, M., Leino Arjas, P., Vahtera, J., et al. (2006). Justice at work and cardiovascular mortality: A prospective cohort study. *Journal of Psychosomatic Research*, 61, 271 to 274.
3. Fanon, F. (1961). *The wretched of the earth*. New York: Grove Press.
4. Ferrie, J. E., Head, J., Shipley, M. J., et al. (2006). Injustice at work and incidence of psychiatric morbidity. *Occupational and Environmental Medicine*, 63, 443 to 450.
5. Fricker, M. (2007). *Epistemic injustice*. Oxford: Oxford University Press.
6. Gouldner, A. W. (1960). The norm of reciprocity: A preliminary statement. *American Sociological Review*, 25, 161 to 178.
7. Greenberg, J., and Cropanzano, R. (Eds.). (2001). *Advances in organizational justice*. Stanford: Stanford University Press.
8. Harman, E. (2004). Can we harm and benefit in creating? *Philosophical Perspectives*, 18, 89 to 113.
9. Kawachi, I. (2006). Injustice at work and health: Causation or correlation? *Occupational and Environmental Medicine*, 63, 578 to 579.
10. King, R. (2010). *People on the move: An atlas of migration*. Berkeley: University of California Press.
11. Kivimaki, M., Elovainio, M., and Vahtera, J. (2003). Organisational justice and health of employees. *Occupational and Environmental Medicine*, 60, 27 to 34.
12. Kivimaki, M., Ferrie, J. E., Brunner, E., et al. (2005). Justice at work and reduced risk of coronary heart disease. *Archives of Internal Medicine*, 165, 2245 to 2251.
13. Kivimaki, M., Virtanen, M., Vartia, M., et al. (2003). Workplace bullying and the risk of cardiovascular disease and depression. *Occupational and Environmental Medicine*, 60, 779 to 783.
14. Kouvonen, A., Kivimaki, M., Cox, S. J., et al. (2005). Job strain, effort reward imbalance, and heavy drinking. *Journal of Occupational and Environmental Medicine*, 47, 503 to 513.
15. Krause, N. M., and Jay, G. M. (1994). What do global self rated health items measure? *Medical Care*, 32, 930 to 942.
16. Leventhal, G. S. (1980). What should be done with equity theory? In K. J. Gergen, M. S. Greenberg, and R. H. Willis (Eds.), *Social exchanges: Advances in theory and research*. New York: Plenum.
17. Moorman, R. H. (1991). Relationship between organizational justice and organizational citizenship behaviors. *Journal of Applied Psychology*, 76, 845 to 855.
18. Parfit, D. (1984). *Reasons and persons*. Oxford: Oxford University Press.
19. Sandel, M. (2012). *What money can't buy: The moral limits of markets*. New York: Farrar, Straus and Giroux.
20. Siegrist, J. (1996). Adverse health effects of high effort low reward conditions. *Journal of Occupational Health Psychology*, 1, 27 to 41.
21. Siegrist, J. (2005). Social reciprocity and health. *Psychoneuroendocrinology*, 30, 1033 to 1038.
22. Siegrist, J., Starke, D., Chandola, T., et al. (2004). The measurement of effort reward imbalance at work. *Social Science and Medicine*, 58, 1483 to 1499.
23. Strawson, P. F. (1974). Freedom and resentment. In P. F. Strawson (Ed.), *Freedom and resentment and other essays*. London: Routledge.
24. Vahtera, J., Kivimaki, M., Pentti, J., et al. (2004). Organisational downsizing, sickness absence, and mortality. *BMJ*, 328, 555 to 558.
25. Woodward, J. (1986). The non identity problem. *Ethics*, 96, 804 to 831.

