At Least You (Should) Have Your Health: Implementing the Right to Health Through the Capability Approach

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ABSTRACT

The United States spends more on health care than any other country in the world, yet health indicators illustrate it is far from the healthiest. This paper argues that improving the country’s health requires us to shift our focus from viewing health as an individual problem to examining potential solutions that are concerned with the public’s health. Once we make this shift, it becomes apparent that we must attend to discrepancies in social determinants of health, such as income, education, and job status, which affect the social gradient of health. These social determinants, which are at the crux of good health, are essential to exercising basic capabilities. After analyzing approaches offered by Aristotle, Martha Nussbaum, Amartya Sen, and Jennifer Prah Ruger, I conclude that the capability approach implements the right to health by suggesting current efforts to address the social determinants of health must be improved upon to actually provide the health outcomes necessary for one to exercise the rights of citizenship the government is supposedly providing and protecting. Through the use of partial ordering and incompletely theorized agreements, the capability approach makes clear how changes can be made to ensure that not only do U.S. citizens have the right to life, liberty, and property, but that they have the capability to actually achieve these rights and the life they choose.
AT LEAST YOU (SHOULD) HAVE YOUR HEALTH: IMPLEMENTING THE RIGHT TO HEALTH THROUGH THE CAPABILITY APPROACH

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The United States spends more on health care than any other country in the world, yet, several health indicators illustrate it is far from the healthiest.1 A key indicator of a population’s health is life expectancy and in general, it’s accepted that being wealthier means living longer. Comparing a wealth indicator, such as the per capita gross domestic product (GDPpc), with a country’s life expectancy tells a different story. For example, the United States’s GDPpc is twenty one thousand dollars higher than that of Costa Rica. Yet, Costa Rica has a higher life expectancy, 76.6 years to 76.4 years.2 This can also be seen in comparable poorer countries. Cuba and Iraq have GDPpc’s of approximately thirty one hundred dollars and, yet, Cuba’s life expectancy is 17.2 years longer.3

Low overall health rankings for the United States do not mean that all Americans are suffering from poor health. Those Americans that are among the most advantaged experience levels of longevity that are among the highest in the world.4 It is the least advantaged Americans that experience levels of health comparable to those of average men and women in developing countries such as those in Africa and Asia, or to Americans fifty years ago, that decrease the

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3 Id.
United States’ overall health ranking among industrialized nations.\textsuperscript{5} It is the fact that there are so many people in these least-advantaged groups tips the scales in the negative direction.\textsuperscript{6}

Improving the country’s health requires improving the health status of a large number of people suffering from health disparities. To meet this goal there needs to be a lesser focus at the individual level, and a greater emphasis placed on the public’s health. The United States government has primary responsibility for the public’s health, and its population has a legitimate expectation of benefiting from public health services.\textsuperscript{7} The government has the resources, power, and duty to provide the services necessary to ensure a healthy society. However, the Constitution, while placing restraints on state action, generally does not provide an affirmative state obligation to provide services or to protect people from harm.\textsuperscript{8} The fact that the government gains its sovereignty and resources from the people, who elect its members and pay taxes, may suggest that an expectation of equal protection and equal opportunity is not unreasonable.

While the United States does have a largely negative Constitution, it does guarantee the right to life, liberty, and property. Implicit in the rights that are guaranteed to citizens by the Constitution is the ability to pursue these rights. Yet, without the right to health, people do not have the capability to try and achieve the fundamental rights that most would agree are a foundation for providing each person with equal opportunity. While numerous countries around

\textsuperscript{5} Id.
\textsuperscript{6} Id.
\textsuperscript{7} LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 6 (Larry Ogalthorpe ed., Univ. of Cal. Press, 2nd ed. 2008) [hereinafter POWER, DUTY, RESTRAINT].
\textsuperscript{8} Id. at 87. The two exceptions to the “no duty to protect rule” are: the government’s duty to a person placed in a custodial setting such as a prison or mental institution who, by reason of the deprivation of liberty, is unable to care for himself; and the government’s duty to protect a person if the state increased the threat of harm so that it is responsible for creating the danger.
the world have accepted this right to health, the United States has been slow to join them. By adopting a right to health and addressing the social disparities that cause the inequalities in health, the United States will take a step toward ensuring an equal opportunity to pursue rights this country holds to be basic and inalienable.

In Part I of this paper, I address why health indicators suggest the United States suffers from poor health, why it is a public health problem, and why public health offers solutions to the problem. Part II addresses the international acceptance of a right to health, why the United States has failed to join this recognition, and potential means to alter the United States’ perception on a right to health. Finally, in Part III, I make an ethical argument for a right to health and the implementation of it through the capability approach.

I. THROUGH THE PUBLIC HEALTH LOOKING GLASS

A. THE GROWING HEALTH CRISIS

Several health indicators suggest that, while spending more money on health care than any other nation, the United States trails behind other industrialized nations in the realized health of its citizens. For example, the 2004 World Health Association placed the United States forty-sixth out of 192 nations in average life expectancy. The question is why the money spent is not resulting in improved health for the country. The answers may lie in the emphasis on addressing individual medical services rather than focusing on the population’s health.

While widespread infectious diseases may not be quite as prevalent today, there are still a growing number of public health problems that affect people around the country. Infectious diseases are still a legitimate concern, as evidenced by the recent spread of the H1N1 virus, as

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10 Erika Blacksher, Health: The Value at Stake, in CONNECTING AMERICAN VALUES WITH HEALTH REFORM 27, 27 (The Hastings Center, 2009).
well as recent fears stemming from the potential outbreaks of avian influenza (bird-flu) and West Nile virus. These concerns show the continued importance of the research, development, production, and equal distribution of vaccines. However, many of the more problematic public health concerns emanate from lifestyles, human behavior, and personal choices. These health problems come in the form of cardiovascular disease, diabetes, and obesity. The abuse and overuse of alcohol, tobacco, and other drugs is another prevalent issue. These problems pervade the lives of millions, in addition to the continued spread of HIV/AIDS and the tragedies caused by diseases such as multiple sclerosis, Parkinson’s, Alzheimer’s, and cancer.

The funds invested into research for the diseases mentioned, such as cancer and AIDS, is important, useful, and abundant. President Obama’s federal budget request for 2010 includes asking for $25.8 billion for HIV/AIDS research. Yet, perhaps because of the association with personal choice, the public health problems linked to lifestyles have significantly less money invested in finding possible solutions. And while individual behavior may play a role in these health issues, these problems are also significant contributors to the life expectancy and mortality rates of this country. Moreover, they significantly increase costs of health care. Diseases such as Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig’s disease) are devastating and deserve to have time, effort, and money put into finding a cure. But the effects of ALS are not felt nearly as strongly by the entire population as hypertension. If the federal funds being used for health are to truly have an impact on the health issues that plague a majority of this country, they need to be used to start addressing the public health problems that implicate social determinants of health such as socioeconomic status.

i. *The Recent Fight Over Health Care and its Failure to Recognize Health and the Social Determinants that Affect Health*

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When discussing the focus on health care rather than health, it is important to distinguish the two from one another. Health care refers to the medical services that prevent and alleviate disease or injury for and individual. Meanwhile health, as defined by the World Health Organization (WHO), is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Health has a much broader scope that includes health care since health care providers can assist in improving health through patient care. Yet, also includes the social determinants that can affect both health and health care.

One of the more commonly pointed to causes of health disparities in this country is the vast amount of people who lack health insurance. In 2008, more than 46 million Americans were uninsured. Among the uninsured, approximately 8.1 million were children. These numbers have been a driving force behind President Obama’s push to alter the health care system to expand coverage of health insurance to the millions currently without any. The thinking is that people who lack insurance coverage suffer from access to medical services and preventative medicine creating lower levels of health. Furthermore, their lack of health insurance creates an increase in medical costs for everyone when they utilize emergency services to treat their serious medical conditions. An increase in health insurance coverage, therefore, should create better health for those previously uncovered, as well as possibly reducing costs paid in emergency medicine and replacing it with cheaper preventative care. As a result, the country’s health as a whole would improve.

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12 POWER, DUTY, RESTRAINT, supra note 7, at 241. See also infra text accompanying note 221–26 (discussing Jennifer Prah Ruger’s definition of health).
13 See Justice, Health, and Healthcare, supra note 2, at 232 (explaining that health is produced not merely by having access to medical prevention and treatment, but also by the cumulative experience of social conditions over the course of one’s life).
The problem with this theory is that evidence suggests that universal access to medical care is not actually going to cure the national health problem. Evidence can be found in the millions of underinsured Americans to see that the answer of universal health insurance is far from a solution to the country’s health problems. Gaps in coverage can create access problems for those who have health insurance. This could be due to a plan that does not cover drugs, dental, or vision. Other problems accessing medical care could be due to an inability to pay previous medical bills.

Further evidence can be found by examining the universal access plans implemented in various countries, which have shown that health disparities do not necessarily disappear by expanding access. A closer look at the United Kingdom, where they have had universal health coverage since the National Health Service was created after World War II, can provide some insight. Despite the long history of universal coverage, the United Kingdom has seen widening inequalities in mortality. There is a distinct socioeconomic gradient of health across all occupational levels where the higher a worker’s occupational status, the longer and healthier their life. In fact, the social gradients in ill health are comparable in the United States and United Kingdom, both in degree and direction. The inability for universal access to healthcare to improve the national health of the United Kingdom suggests that the United States may want to refocus their attention on other factors contributing to poor health.

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18 Norman Daniels, *Justice and Access to Health Care*, STANFORD ENCYCLOPEDIA OF PHILOSOPHY 1, 5 ( Winter 2008) [hereinafter Justice and Access], http://plato.stanford.edu/archives/win2008/entries/justice-healthcareaccess/. This difference is not explained by risk factors associated with occupational status, such as smoking rates or lipid levels or other “lifestyle choices,” nor is it a result of deprivation because none of the participants are poor, lack basic education, or medical care.
19 Marmot, supra note 17, at 404.
This is not to say that increasing health care coverage or providing universal access is not helpful or a waste of resources. It is merely to suggest that it is not the magic bullet. Other factors affecting people’s health must be addressed; yet, the recent fight over health care has ignored the fact that universal access to health care alone will not eliminate the link between health and other social factors. Health care is only one of the many determinants of health, and some would suggest a relatively minor one. A person’s health is affected by where they live, where they work, how much money they make, and various other social factors. The social determinants have a greater impact on health than access to medical prevention and treatment. To truly address the health of the nation, the inequalities in these social factors cannot be ignored.

ii. Consequences of a Lack of Health

A lack of health is important to address because of the effects it has on the individuals who are suffering from poor health, as well as the effects it can have on the entire population. The right to health is so essential because without minimum levels of health people cannot fully exercise their rights of citizenship. A healthy individual can participate in the political process, generate wealth, and provide for the common security. The ability of more people to participate benefits everyone in the population. A healthier individual is capable of participating more in the governmental process, and the more participation in our representative form of government, the more the electorate reflects the population as a whole. Similarly, a healthy individual can contribute to economic prosperity, with a strong economy advancing everyone’s

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20 Justice, Health, and Healthcare, supra note 2, at 231.
21 Blacksher, supra note 10, at 27.
22 Gopal Sreenivasan, Opportunity is Not the Key, in ETHICAL ISSUES IN MODERN MEDICINE 235, 235 (Bonnie Steinbock, Alex John London & John D. Arras eds., 2009).
23 POWER, DUTY, RESTRAINT, supra note 7, at 8.
24 Id.
daily life. But a certain level of health is a prerequisite for a person to function in social, political, and economic activities that contribute to the public’s welfare.\(^{25}\)

Without addressing the right to health for all Americans, the government has created a cyclical problem where bad health produces more bad health. For example, the income inequality leads to educational inequality which leads to health inequality.\(^{26}\) Income inequality causes higher levels of social mistrust and reduces participation in civic organizations.\(^{27}\) This leads to a lack of political participation, which undermines the governmental responsiveness in addressing the needs of these people who are worse off.\(^{28}\) This is shown in States where they have the highest income disparities and, perhaps as a result, invest the least in public education and spend less on social safety nets.\(^{29}\)

B. SHifting the Focus FROM Health Care TO Health

i. Using the Public Health Lens

Public health is concerned with the health status of the population, rather than the individual. The Institute of Medicine has defined public health as what we, as a society, do collectively to assure the conditions for people to be healthy.\(^{30}\) It could be said that by spending more money than any other country, the United States is doing its part to try and provide the conditions necessary for its citizens to be healthy. Yet, spending the most money has left the United States in a financial crisis and with little to show comparatively on leading health indicators.

Therefore, it seems apparent that despite the efforts being undertaken, the United States is in fact not assuring conditions for people to be healthy. Public health problems, such as obesity,

\(^{25}\) Id.
\(^{26}\) Justice, Health, and Healthcare, supra note 2, at 233.
\(^{27}\) Id.
\(^{28}\) Id. at 234.
\(^{29}\) Id.
diabetes, hypertension, are ones affecting a wide range of people in important large scale measures and they require public solutions. The government is best situated to be able to provide these solutions.

Public health law is concerned with the duty and powers of the state to ensure the conditions necessary for people to be healthy, while simultaneously factoring in the limitations on the power of the state to constrain the autonomy, privacy, liberty, and other legally protected interests of individuals.\(^3\) Public health is supposed to pursue the highest levels of health for all individuals through fair and equitable treatment of groups and individuals. Public health problems are ones that cannot be left to the individuals alone to solve. A classic example of this problem is vaccinations for infectious diseases. If left to individuals to decide, there may not be enough people who choose to take the vaccination to prevent the spread of the disease in question. Even public health issues that implicate personal choice, such as obesity, are influenced by the societal gradient, such as the expense and lack of access to healthy foods. An unhealthy population in general may result in harm to all. An unhealthy community is more likely to have increased violence and crime, impaired social relationships, and a less productive workforce.\(^2\) To avoid these types of problems, people must be willing to sacrifice some of their individual interests to assure themselves a healthier, safer, more productive community.\(^3\)

\(^3\) _Power, Duty, Restraint_, supra note 7, at 4.
\(^2\) Id. at 7.
\(^3\) There is spectrum of sacrifices one may be asked to make that can range from slight inconveniences to what may be considered substantial sacrifices to individual liberty. Examples of small inconveniences include having your public water fluoridated. _See_ Quiles v. City of Boynton Beach, 802 So.2d 397, 399 (Fla. Dist. Ct. App. 2001) (stating that the city adding fluoride into water before it enters households is not overly intrusive given the fact that any resident can alter the water or not drink it). A more moderate inconvenience would be a helmet or seat belt law. _See_ Benning v. Vermont, 641 A.2d 757, 762 (Vt. 1994) (finding that there is no constitutional barrier to legislation requiring motorists to wear helmets as a preventative measure to minimize health care costs that are inevitably imposed on society). Major sacrifices would include forced vaccinations and taxation of earnings for distribution to services that don’t necessarily benefit the individual being taxed. _See_ _Power, Duty, Restraint_, supra note 7, at 378 (stating that compulsory vaccinations are an example of the state explicitly asking parents to forgo their right to decide the welfare of their children for the public good).
The government, which is created to pursue the common good, must engage in measures aimed at improving the public’s health, since this is a goal that can only be attained through collective action. Great strides in health and life expectancy were made due to improved water, food, and milk sanitation, as well as vaccines and antibiotics. Yet, these improvements that benefited the public as a whole would not have been possible through individual efforts alone. The government provided funds and has the authority to ensure the advancement of the public’s health. Since the country as a whole has a vested interest in efforts to improve the sanitation, water and air quality, and prevention and treatment of diseases, the government exercising authority to regulate and make improvements in these fields is less likely to be questioned. And with the resources to attack these issues, which are provided through the public, the government is not only obligated to strive for solutions but it is the only entity equipped to do so.

ii. Health is a Precondition to Making Health Care Useful

Since it appears that even a program of universal access cannot guarantee improvements in a population’s health, the conditions affecting health needs to be addressed. This further illustrates the fact that this issue is a public health issue. For the role of public health is to “assure the conditions for people to be healthy.” The conditions affecting health are a variety of factors falling into categories of educational, economic, social, and environmental.

It is well documented that the socioeconomically advantaged have lower mortality, morbidity, and disability rates. A person’s health is not only affected simply by having access to medical prevention and treatment, but also by a person’s social positioning and the underlying
inequality in our society.\textsuperscript{39} So, while universal access to healthcare would be an important step in addressing the needs of the underprivileged, it would not solve the problematic link between social status and health.\textsuperscript{40} The disparities between health statuses are not present only on the socioeconomic extremes. For example, the association between socioeconomic position and mortality has been shown to be present in the middle socioeconomic ranges as well.\textsuperscript{41} Therefore, for health care to have the impact that may be expected, the social determinants of health need to be addressed.

II. THE UNITED STATES' FAILURE TO RECOGNIZE A RIGHT TO HEALTH

A. INTERNATIONAL RIGHTS TO HEALTH

While the United States is not bound by the actions or political tendencies of the rest of the world, it is a part of a global society that should be working to the betterment of all people. This sentiment led to the creation of the United Nations and motivated the United States to join the global fight against AIDS\textsuperscript{42} and other infectious diseases worldwide.\textsuperscript{43} Examining international law, as well as the Constitutions of several countries, makes the importance of health impossible to ignore.\textsuperscript{44} Yet, the right to health is one global movement the United State has been loath to join.

i. Recognition by International Organizations

International organizations have long supported the idea that all people have a right to health. The United Nations’ Universal Declaration of Human Rights states, “everyone has the right to a standard of living adequate for the health and well-being of himself and of his

\begin{footnotes}
\item[39] Justice, Health, and Healthcare, supra note 2, at 231–32.
\item[40] Id. at 31.
\item[41] Institute of Medicine, supra note 4, at 30.
\item[44] Kinney & Clark, supra note 9, at 328.
\end{footnotes}
family." It goes on to state that everyone has the right to life, liberty, security of person, education, and the right to freely participate in the cultural life of the community. These rights are universal, entitled without any discrimination to equal protection of the law, and create in everyone duties to the community. While this document is not legally binding, the United States did vote in support of passing the declaration, as did many other countries. Further evidence of the right to health can be found in General Comment 14 of the International Covenant on Social, Economic, and Cultural Rights, which defines health and recognizes “the right of everyone to the enjoyment of the highest attainable standard of mental and physical health.” Yet, other countries have incorporated the right to health into their own Constitutions, while the United States has abstained from creating such a right.

ii. Right to Health Recognition by Individual Nations

Both large industrialized nations, as well as smaller developing countries, have incorporated the right to health into their constitutions. For example, Italy’s constitution states that “The Republic safeguards health as a fundamental right of the individual and as a collective interest.” This emphasizes not only the individual’s right to health, but places it in the context of the governmental duty to protect the entire country’s interest in being healthy, recognizing the importance of the public’s health. In a developing country such as Brazil, “Health is the right of all and the duty of the State and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities

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49 Kinney & Clark, supra note 9, at 328.
and services for its promotion, protection and recovery.”51 The constitution also says that “health activities and services are of public importance,”52 placing the concept of the right to health in the context of public health. Even a country such as China, where the rights of the individual may be questioned, has a requirement that the state develop medical and health services to protect the people’s health.53 Not only are there industrialized countries that find that the government has a responsibility to provide health services, but there are countries that fall along every part of the financial spectrum declaring health as a right and the public’s health as a duty of the government to maintain.

B. DOMESTIC IMPEDIMENTS

i. Legislative Failures

The concept of a right to health in the United States can be viewed through the debate over universal health care. The idea of providing the citizens of the United States with universal health care coverage has been around for some time. Both the federal government and state governments have made numerous attempts to pass universal health care legislation. In each instance there has been strong opposition from politicians seeking to preserve traditional private health care coverage. To date, the fight for universal health care has had little success. These legislative stalemates demonstrate not only the failure to recognize a right to health, but a right to health care as well.

1. The State Level

In spite of several state proposals and pushes from various groups and politicians, all state plans for universal health coverage have failed to become fully implemented with the exception of Massachusetts. Problems have come in various forms. Making use of an employer

51 Kinney & Clark, supra note 9, at 310.
52 Id.
53 Id. at 313.
mandate can be difficult given the preemptive restrictions found in the Employee Retirement Income Security Act of 1974 (ERISA), as Maryland found out.\textsuperscript{54} Another issue was the fear that mandating health insurance by employers would result in drastic cuts to jobs, increasing unemployment.\textsuperscript{55} Others found supportive critics by condemning the utilization of individual mandates. Besides the obvious infringement on freedom of choice, some argued that forcing insurance on people would not help to make them financially secure, but rather shift around the insecurity and undercut the health delivery goals.\textsuperscript{56} In fact, some argued that individual mandates coupled with an affordability threshold could result in medical debt and other financial problems that would deter people from seeking health care.\textsuperscript{57}

2. The Federal Level

a. The Clinton Administration

During President Clinton’s time in office, the public was both supportive of significant health reform and unsettled about expanding the role of the government.\textsuperscript{58} Despite rising costs and weak governmental controls to corral it, providers, private purchasers, and insurers were able to use the public’s fear of governmental control as a way to resist budgetary control.\textsuperscript{59} Placing health reform high on their priority list at the time, different polls found that 60 to 70 percent of

\textsuperscript{54} Amy B. Monahan, Symposium: The Massachusetts Plan and the Future of universal Coverage: Regulatory Issues: Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts, 55 KAN. L. REV. 1203, 1205 (2007) (stating that the Supreme Court struck down a Maryland statute requiring employers with more than ten thousand employees in the state to either (1) contribute 8% of their payroll to employee health care or health insurance, or (2) pay to the state an amount equal to the difference between what the employer spend on employee health care and 8% of payroll).

\textsuperscript{55} Employer Health Insurance Mandates and the Risk of Unemployment – Katherine Baicker and Helen Levy for National Bureau of Economic Research pg 15


\textsuperscript{57} Id. at 109.


\textsuperscript{59} Id. at 630.
Americans favored a national health insurance plan.\(^{60}\) While the uninsured increasingly became those who were neither poor nor unemployed, there was a perception that universal coverage would only be a benefit to a minority of Americans.\(^{61}\)

Although autonomy and freedom of choice was a factor, it was not the only one leading to the apprehension toward the government taking a larger role in guaranteeing universal coverage. There was concern over the bureaucracy and practical limits of what the government can accomplish, with confidence in the government on a steady decline.\(^{62}\) This lead to fears of increasing costs and decreasing quality of treatment, as well as opposition to a restriction on freedom implemented through a yearly dollar limit on total private and government spending for all health care.\(^{63}\) In addition to the fears of impinging on their freedoms, Americans were not thrilled with the idea of paying for a system, through increased taxes, that they were unsure would improve health care. Genuine concern over infringing on doctor-patient relationships and the timeliness of treatment all contributed to the downfall of President Clinton’s goal of universal coverage.\(^{64}\) Of course, the well-financed and well-organized lobbyists against the plan did not hurt.\(^{65}\) The problem was that while the public wanted something done, they had serious doubts about how President Clinton was proposing to do it.\(^{66}\)

b. The Obama Administration

To observe the debate over a right to health, and health care, in the United States one need not look much further than the front page of any newspaper. For months, President Obama’s attempt at broadening health insurance coverage has been the topic of much

\(^{60}\) Id. at 632. \\
^{61}\) Id. at 634. \\
^{62}\) Id. at 634–35. \\
^{63}\) Id. at 635. \\
^{64}\) Id. at 636. \\
^{65}\) Id. at 644. \\
^{66}\) Id. at 648.
controversy and debate. And while the concept of providing coverage may be somewhat agreed upon, the implementation certainly is not. One of the key components of debate is the public option, the avenue for which the government actually could provide a plan to cover certain Americans. It appears that some see this as a potential movement toward a governmental takeover of the health care industry, not unlike the fear propagated during the Clinton administration. As a result, the government’s attempt to ensure affordable coverage appears to be falling by the wayside so that the rest of the proposal can finally move forward. Meanwhile, Congress cannot even agree on how the systems already in place should be run in the future. Contentions arose out of provisions to alter the Medicare system and the creation of a new long-term-care insurance program.

While the debate over provisions of the new health care bill rage on, it is worth noting that at some point there will be some type of health care reform put into legislation with the supposed aim of increasing health insurance coverage and reducing costs. This push for increased coverage does not approach the acceptance of a right to health, but President Obama has made the plea that universal access is what should happen since before he became president. And since he has taken office, President Obama has called for a new era of responsibility, pushing the demands of health not only on individuals but on society as a whole, which should result in a movement toward promoting health for all.

ii. Poor Federal Funding Choices

Another pivotal piece of evidence demonstrating the United States’ failure to recognize a right to health is the funding choices made by the federal government. When examining the

67 Shailagh Murray & Lori Montgomery, Senate May Drop Public Option, WASHINGTON POST, Dec. 9, 2009.
70 Blacksher, supra note 10, at 28.
2010 budget, it becomes apparent where the White House’s priorities lie. The Department of Defense has a budget of $533.8 billion, an increase of over $20 billion. With the military spread throughout the world and large numbers of troops stationed in Iraq and Afghanistan, this may not be a surprise to many. The war on terror, however, also demands that the Department of Homeland Security be granted a budget of $42.7 billion. The Defense budget, while large, is apparently unable to cover the security priorities that range from border control to cybersecurity.

Even investigating the choices of allocation for the $76.8 billion budgeted for the Department of Health and Human Services provides some insight into the government’s priorities. Besides the focus on health care reform, which aims to increase the health insurance coverage, the budgeting decisions also reflect a concentration on health care rather than health. Treatment of cancer is a high priority with cancer research getting $6 billion, which is separate from the $10 billion provided in the American Reinvestment and Recovery Act of 2009. Meanwhile, investments in programs developed to assist with children from ages zero to five totals $4.1 billion.

Again, this evaluation of federal funding is not to suggest that the items receiving large sums of money are unworthy. But according to important health indicators, the government’s failure to recognize a right to health, and the social determinants that affect the population’s

75 Id.
76 Id.
health, seem to have an impact. The Department of Health and Human Services is simply a microcosm of the much larger national health care industry. In 2005, the United States spent $1.988 trillion on health care, or approximately 16% of its GDP. The majority of funding in the health care delivery system is public and, as such, a significant portion of this money should be used to ensure the health of the public. This goal can only be achieved by examining the factors that result in low health status for certain populations. While the United States has consistently placed funds into clinical care and biomedical technology research, it has failed to make the same level of commitment to population health promotion and disease prevention. Furthermore, issues of social and behavioral conditions influence health factors; yet, they are rarely examined or addressed.

iii. The Negative Constitution

77 Examining one social determinant of health, education, is an example of the government’s priorities related to these determinants. Yet, comparing the defense funding to the Department of Education’s budget of $46.7 billion would give the impression that this is a debate between funding security or education, which is hardly the point. Freedom from fear of violence and terror certainly factor into the mental health of many Americans, and no one would argue that defense and security of the nation qualify as superfluous priorities. The aim of the question is simply to observe the funding priorities of the government and determine what message it conveys about what deserves financial backing. For example, a comparison of the budget for education, consistently held by politicians as a focal point of theirs during any campaign, with the $18.7 billion budgeted for the National Aeronautics and Space Administration, can aid the determination of whether there is warrant for concern. Another goal in examining the government’s funding choices is to begin to recognize that, as stated previously, the determinants of health go well beyond the realm of health insurance coverage. Socioeconomic factors must be addressed if the health of this nation is to improve. While educational funding has been discussed, another important factor for health is shelter, and during the recent mortgage crisis, this has played an increasingly important role. Yet, at a time when the need for affordable housing may be at its peak, the Department of Housing and Urban Development’s budget of $47.5 billion is still below what it was in 2006.


79 Institute of Medicine, supra note 4, at 27.
Any justification to the government’s failure to address health disparities starts with the concept that our Constitution is largely cast in negative terms. The Constitution states throughout what the federal government is not to do – for example, creating laws that abridge an individual’s freedom of speech – but there is a lack of an affirmative obligation on the government to act and provide certain services, with few exceptions. Furthermore, the model of a negative Constitution has been consistently upheld by the United States Supreme Court.

1. DeShaney v. Winnebago County Department of Social Services

In DeShaney v. Winnebago County Department of Social Services, the Court held that nothing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors. This case involves a young boy named Joshua whose custody was given to his father when his parents divorced in 1980. Between January 1982 and March 1984, there were five incidents of suspected child abuse that were investigated by Department of Social Services (DSS). The investigations included placing Joshua under temporary custody of the hospital, the creation of a “Child Protection Team,” and household visits from caseworkers. It was observed during follow-up visits that there were suspicious injuries and court recommendations were not being followed, yet, the only actions the DSS took was noting their observations and their suspicions that Joshua was being abused by someone.

80 POWER, DUTY, RESTRAINT, supra note 7, at 87.
81 U.S. CONST. amend. I.
82 POWER, DUTY, RESTRAINT, supra note 7, at 87 (giving an example of an exception being a right to an attorney in a criminal trial).
84 Id. at 258.
85 Id. at 191.
86 Id. at 192–93.
87 Id.
88 Id.
The last visit to the hospital in March of 1984 was the result of a beating Joshua received from his father that left him in a life-threatening coma that he would survive, but with severe brain damage caused by traumatic injuries to the head inflicted over a long period of time. The suit was brought by Joshua and his mother against the county, its department of social services, and various individual DSS employees, alleging that Joshua was deprived of his liberty without due process of law because of the failure to intervene to protect him against a risk of violence which they knew of or should have known.

The Due Process argument was that Joshua was denied not his procedural rights, but substantive rights because the State was obligated to protect Joshua in these circumstances. The Court held that the phrasing of the Clause created a limitation on the State’s power to act, rather than creating a guaranteed minimum of certain levels of safety and security. Therefore, the Due Process Clause does not create an affirmative obligation on the State to ensure that a person’s interests do not come to harm through means other than the actions of the State. The Court held that the intent of the Amendment was to prevent the government from abusing its power, not to protect people from each other.

2. Webster v. Reproductive Health Services

In Webster v. Reproductive Health Services, five health professionals employed by the state and two nonprofit corporations brought suit over a Missouri statute which prohibited the use of public employees and facilities to perform or assist abortions not necessary to save the

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89 Id.
90 Id.
91 Id. at 195.
92 Id.
93 Id.
94 Id. at 196.
mother’s life.\textsuperscript{96} The Court felt that the State was simply deciding to use public facilities and staff to encourage childbirth over abortion.\textsuperscript{97} According to the Court, this placed no governmental obstacle in the way for a woman who wished to have her pregnancy terminated.\textsuperscript{98} Nothing in the Constitution required States to take part in the abortion process, nor did patients or physicians have the constitutional right to access public facilities to have their abortions performed.\textsuperscript{99} In this case the Court relied heavily on \textit{DeShaney}, stating that the Due Process Clauses confers no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.\textsuperscript{100}

3. Town of Castle Rock, Colorado v. Gonzales

In another case of tragic consequences, \textit{Town of Castle Rock, Colorado v. Gonzales},\textsuperscript{101} the Supreme Court again displayed its unwillingness to extend affirmative obligation on the government to act when citizens rely on their actions. In \textit{Castle Rock}, the plaintiff attempted to circumvent the earlier decisions regarding the Due Process Clause by claiming a violation of her procedural due process right, rather than claiming a substantive violation as done in the previous cases discussed.\textsuperscript{102} In this case, the plaintiff had a restraining order against her husband and sought enforcement of this order by the local police when her three daughters were taken by their father in violation of that order.\textsuperscript{103} Despite a notice on the order to law enforcement that they were to use “every reasonable means to enforce [the] restraining order,” the plaintiff was continually told to wait until the children were returned home.\textsuperscript{104} Instead, the father showed up

\begin{itemize}
\item \textsuperscript{96} Id. at 501.
\item \textsuperscript{97} Id. at 509.
\item \textsuperscript{98} Id.
\item \textsuperscript{99} Id. at 510.
\item \textsuperscript{100} Id. at 507.
\item \textsuperscript{101} 545 U.S. 748 (2005).
\item \textsuperscript{102} Id. at 755.
\item \textsuperscript{103} Id. at 751–53.
\item \textsuperscript{104} Id. at 752–54.
\end{itemize}
at the police station almost ten hours after the initial call to police, and after six pleas from the mother for the police to act, firing on the station and was subsequently shot and killed.\textsuperscript{105} Afterward, the police found the plaintiff’s three daughters murdered in the father’s truck.\textsuperscript{106}

The plaintiff claimed that she had a property interest in the enforcement of the restraining order and, therefore, the police deprived her of her property rights without due process of law.\textsuperscript{107} The Court held that enforcement of a restraining order does not constitute a property interest for purposes of the Due Process Clause.\textsuperscript{108} To have a property interest in a benefit, the person must clearly have a legitimate claim of entitlement to that benefit, and since the protection under a restraining order is discretionary, this would not qualify.\textsuperscript{109} This holding was made in spite of the state of Colorado’s apparent attempt to dictate that the terms of the order be enforced.\textsuperscript{110} So, while some may see police protection against violence as governmental service as valuable as any other, the Court once again showed its hesitance to afford an affirmative obligation and cement the fact that governmental inaction rarely constitutes in a constitutional remedy.\textsuperscript{111}

C. \textbf{ARGUMENTS AGAINST THE NEGATIVE CONSTITUTION}

\textit{i. Shelley v. Kraemer}

While the Constitution is written negatively, apparently alleviating the government’s duty to provide its citizenry with certain services, there is also an inherent right read into certain governmental restraints. For example, the Constitution states that the government may not abridge the freedom of speech. It is not a stretch to say that this implies that people have a right to free speech. Similarly, no State may deprive someone of life, liberty, or property without due

\begin{itemize}
  \item \textsuperscript{105} \textit{Id.} at 754.
  \item \textsuperscript{106} \textit{Id.}
  \item \textsuperscript{107} \textit{Id.}
  \item \textsuperscript{108} \textit{Id.} at 766.
  \item \textsuperscript{109} \textit{Id.} at 756.
  \item \textsuperscript{110} \textit{POWER, DUTY, RESTRAINT, supra} note 7, at 89.
  \item \textsuperscript{111} \textit{Id.}
\end{itemize}
process of law. This point is illustrated by the fact that the Fourteenth Amendment has been said to guarantee certain individual rights. In *Shelley v. Kraemer*, the Court states that "Equality in the enjoyment of property rights was regarded by the framers of [the Fourteenth] Amendment as an essential pre-condition to the realization of other basic civil rights and liberties which the Amendment was intended to guarantee." Here the Court mentions that there are basic civil rights and liberties that the Constitution, through the Fourteenth Amendment, guarantees. As such, the Court finds no problem upholding the right to property.

While the right to health may not be a basic civil right or liberty that the Constitution explicitly guarantees, it may be an essential pre-condition to the realization of those guaranteed rights. Similarly, it may be possible that denying someone their right to health and, consequently, their basic rights and civil liberties, may also be denying that person equal protection under the law.

**ii. Obligation to Public Health Implied at the Constitutional Framing**

The Constitution was created to ensure the pursuit and protection of the common good. While the common good may not be necessarily clear, it appears that public health would be included. In this era, individual rights were acceptably limited because they were to be realized by achieving this common good, which the government then was obligated to pursue. The public good could only be achieved if the public health was incorporated in it. As such, the

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112 334 U.S. 1 (1948).
113 See generally Frank I. Michelman, Foreword: On Protecting the Poor Through the Fourteenth Amendment, 83 Harv. L. Rev. 7 (1969) (stating that claims equality, or at least an effective minimum protection, with regards to poverty may be found in the Fourteenth Amendment).
114 Wendy Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, in *PUBLIC HEALTH LAW AND ETHICS: A READER* 163, 164 (Lawrence O. Gostin ed., 2002) ("eighteenth century belief in government’s compact obligation to fulfill the common good is consistent with the pattern of regulation and provision evident in colonial and early federalist public health regulations.").
115 *Id.* at 164–65 (stating protection against epidemics as evidence).
116 *Id.* at 167.
government that fails to protect the public’s health and, therefore, pursue the common good, violates the grounds on which it gains its authority.\textsuperscript{117}

The innate connection between the pursuit of the common good, arguably the main purpose in forming a government, and the public’s health may explain the lack of an affirmative duty to protect the public’s health in the Constitution.\textsuperscript{118} In the Framer’s era, the government was not only quick to act in the hopes of protecting the public’s health, it was expected to do so. Property would be limited, and even impounded, and individual rights of travel and access to one’s home were curtailed in the name of the government’s public health power.\textsuperscript{119} In an age when disease and epidemics was an ever-present threat to self and property, the common good required governmental action.\textsuperscript{120} Therefore, individuals gave up certain rights in exchange for the government fulfilling its obligation to provide care and protection against these epidemics and plagues.

\textit{iii. Ideological Argument Against the Negative Constitution}

Besides attempting to alleviate the argument of a completely negative Constitution on legal terms, a greater problem may be changing the ideological acceptance of the negative Constitution.\textsuperscript{121} Solidarity is a principle of communitarian morals, where mutual responsibility governs the actions of the population.\textsuperscript{122} In terms of health, this would include universal health care, equitable access to care, and the concept that in the face of illness and the threat of death,

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{117} \textit{Id.} at 166.
\item \textsuperscript{118} \textit{Id.} at 168.
\item \textsuperscript{119} \textit{Id.} at 167.
\item \textsuperscript{120} \textit{Id.} at 166.
\item \textsuperscript{121} Health is connected to the individually protected rights of life, liberty, and property. An understanding and acceptance of health as a necessary precursor to the rights protected by the Constitution would demonstrate the ability to accept a right to health without altering the view of the negative Constitution. \textit{See infra} Part III (explaining how health is a central capability and essential for an individual to be able to pursue and fulfill their constitutionally protected rights).
\item \textsuperscript{122} DAN CALLAHAN, \textsc{Medicine and the Market} 90 (The Johns Hopkins University Press 2006).
\end{itemize}
\end{footnotesize}
we are all bound together by common needs that require a community response.\textsuperscript{123} With an emphasis placed on personal autonomy, “solidarity has long been out of vogue in America’s value system.”\textsuperscript{124}

Part of the reason other countries, especially those in Western Europe, embrace the solidarity viewpoint is their historical approach to health care. National health policies began in Germany in 1889, when they had a comprehensive system covering the elderly, retirement, disability, sickness, and workers’ compensation.\textsuperscript{125} Despite solidarity’s emphasis on communities working together to solve a common problem, initially the Germans developed this system to create a better workforce and maximize efficiency.\textsuperscript{126} This is an equally valid argument for solidarity considering one person’s illness can spread through families, clubs, churches, and harm the workplace in a variety of ways.\textsuperscript{127} Yet, this notion has evolved into an idea of social citizenship, where citizens put aside their personal rights to some degree in favor of a universal standard of entitlement.\textsuperscript{128}

As seen in the constitutions of numerous other countries around the world, the acceptance of a right to health is not only part of their ideological view of health care, it is a legal right as well. Many countries even cite the international laws stated earlier in this paper as grounds for everyone’s right to health.\textsuperscript{129} Because these countries recognize this right, “equitable access for all citizens, regardless of their ability to pay, is well entrenched as a value and benchmark for all reforms.”\textsuperscript{130} So entrenched is this value, that the few countries that gave into pressures and

\begin{footnotesize}
\begin{enumerate}
\item\textsuperscript{123}Id.
\item\textsuperscript{124}William M. Sage, Solidarity: Unfashionable, But Still American, in Connecting American Values With Health Reform 10, 10 (The Hastings Center, 2009).
\item\textsuperscript{125}CALLAHAN, supra note 122, at 88.
\item\textsuperscript{126}Id.
\item\textsuperscript{127}Sage, supra note 124, at 10.
\item\textsuperscript{128}CALLAHAN, supra note 122, at 89.
\item\textsuperscript{129}Id. at 90.
\item\textsuperscript{130}Id. at 109.
\end{enumerate}
\end{footnotesize}
changed their system to a more market based approach quickly changed back. One of the
important features of a solidarity based system is the obligation that citizens have to financially
contribute to the system’s maintenance. This concept certainly contradicts the United States’
individualistic preference, and conflicts with the view held by some Americans that
comprehensive welfare programs are inherently “socialist.”

And while the solidarity system typically grows out of community need, rather than being
forced upon a population, a more forceful ideological change may be necessary for the concept
to catch on in the United States. While this may seem like a lost cause, evidence may suggest
otherwise. Mutual assistance already exists in public programs such as Medicaid and Medicare,
but it also exists in the private health insurance plans where group rates for employees are
redistributing resources from healthier to sicker members of the workplace risk pools. Health
solidarity is seen in the United States when people with similar goals come together to fight
cancer, ensure human rights through health, or protect the health rights of veterans. Furthermore, health solidarity can come in the form of more widely accepted governmental
intrusion. Examples of this come in governmental responses to epidemics and disasters,
regulation of smoking, and investment in hospitals and public education. With these building
blocks, it may be possible to bring the individualistic attitudes of Americans closer to the idea of
accepting a nation of solidarity.

III. AN ETHICAL ARGUMENT FOR A RIGHT TO HEALTH
With potential issues arising for both a legal and ideological argument for a right to health, this paper aims to make the case on ethical grounds. Making an ethical contention for a right to health is hardly something new and there are various approaches that exist. This paper explores two closely related approaches, a resources-oriented view and a results-oriented view. Ultimately, finding credence in some of the criticisms of the resources-oriented view, I suggest that the results-oriented view, as posited in the capability approach, makes the more compelling argument.

A. THE RESOURCES-ORIENTED VIEW

i. John Rawls and Justice as Fairness

John Rawls’s *A Theory of Justice* (1971) was the first proposal of justice as fairness, a social contract theory that states that the most reasonable principles of justice are those of mutual agreement by persons under fair conditions. One of the fundamental ideas presented is the original position, which answers how to specify the fair terms of cooperation when organizing a society as of free and equal persons. To stipulate a point of view from which a fair agreement between free and equal persons can be reached, the point of view must be kept from distortion by removing it from the particular features and circumstances of the existing structure. To prevent some from having unfair bargaining advantages over others, as well as eliminating threats of coercion and fraud, the original position puts people behind a veil of ignorance where people cannot know the social positions they are in. This ensures that historical advantages

[139] *Id.* at 15.
[140] *Id.* (stating that this includes not knowing one’s race and ethnic group, sex, or various native endowments such as strength and intelligence).
and accidental influences from the past do not influence an agreement on principles that are to regulate from the present to the future.\textsuperscript{141}

With a lack of relative societal placement, the decisions made by the cooperative whole would be those that would benefit all, rather than those that benefit a select few based on some particular characteristic. Yet, this still leaves the question of what principles of justice are most appropriate to specify basic rights and liberties, and to regulate social and economic inequalities.\textsuperscript{142} Rawls argues that in the original position people would arrange social and economic inequalities so that they are both to the greatest benefit of the least advantaged and attached to offices and positions open to all under conditions of fair equality of opportunity.\textsuperscript{143}

Using these principles, Rawls argues that a maximin strategy should be used when determining the distribution of social goods. The maximin strategy states that we choose the option whose worst outcome is better than the worst outcome of any other alternatives.\textsuperscript{144} This compliments Rawls’s difference principle, which states that inequalities in goods like income and wealth are just only if, as a result of the inequality, the social group that is least-advantaged in terms of these goods is better off than it would otherwise be.\textsuperscript{145} These principles, when combined with the original position, require that society implement a system that makes the worst-off better than they would be in any other system, while maintaining citizens’ equal basic liberties and fair equality of opportunity.\textsuperscript{146}

\textit{ii. Norman Daniels}

\begin{footnotesize}
\textsuperscript{141} Id. at 16.
\textsuperscript{142} Id. at 41.
\textsuperscript{143} Stuart White, \textit{Social Minimum}, STANFORD ENCYCLOPEDIA OF PHILOSOPHY 1, 17 (Fall 2008), http://plato.stanford.edu/entries/social-minimum/.
\textsuperscript{144} Samuel Freeman, \textit{Original Position}, STANFORD ENCYCLOPEDIA OF PHILOSOPHY 1, 20 (Spring 2009),http://plato.stanford.edu/entries/original-position/.
\textsuperscript{145} White, supra note 143, at 17.
\textsuperscript{146} Freeman, supra note 144, at 20.
\end{footnotesize}
Norman Daniels applies Rawls’s principles of justice to health and health care to
determine if a right to either exists. Daniels argues that while Rawls does not mention health
care as a special social good, it should be considered such due to its impact on opportunity.\textsuperscript{147} If
equality of opportunity is a goal of Rawlsian justice, then health care is special because disease
and disability impair normal functioning and restrict the opportunities open to individuals.\textsuperscript{148}
This includes not only equal access to medical prevention and treatment, but to public health
measures as well, for those measures have the effect of reducing risk equitably.\textsuperscript{149} Equal
opportunity does not require all opportunities be equal for all persons, but rather that opportunity
be equal for persons with similar skills and talents.\textsuperscript{150} Thus, health care prevents disease and
disability from restricting individuals’ opportunities relative to what would be available given
their skills and talents if they were healthy.\textsuperscript{151}

Within this health care system, governed by the moral function of guaranteeing equality
of opportunity, Daniels argues that a decent basic minimum must be available to everyone.\textsuperscript{152}
Furthermore, no obstacle, whether it be financial, racial, or geographical, should impede access
to this basic minimum.\textsuperscript{153} Yet, Daniels discovered in later works, that these social determinants
do have an effect on one’s access to a decent basic minimum. So, Daniels argues that access to
universal health care alone does not produce health, because health is affected by the cumulative
experience of social conditions over the course of one’s life.\textsuperscript{154}

\textsuperscript{147} Justice, Health, and Healthcare, supra note 2, at 231.
\textsuperscript{148} Id.
\textsuperscript{149} Justice and Access, supra note 18, at 26.
\textsuperscript{150} Norman Daniels, Equal Opportunity and Healthcare, in ETHICAL ISSUES IN MODERN MEDICINE 200, 200 (Bonnie
\textsuperscript{151} Id. at 201.
\textsuperscript{152} Id. at 202.
\textsuperscript{153} Id.
\textsuperscript{154} Justice, Health, and Healthcare, supra note 2, at 232.
Since the link between social determinants and health cannot be broken by providing access to medical prevention and treatment, ensuring equality of opportunity requires improving the social and political well-being of individuals as well. In Daniels’s alteration of Rawls’s theory of justice, he argues that meeting the basics of Rawlsian justice would significantly reduce the most important injustices in health outcomes. In this way, Daniels’s right to health care morphs into a right to health. The right to health implies that there is an obligation to perform certain actions that affect health, even if they are not normally construed as health care services and if they involve factors outside the health sector. Equality of opportunity demands access to high quality public education, early childhood interventions, as well as universal coverage for appropriate health care. Likewise, the difference principle would contribute to reducing the socioeconomic inequalities.

B. CRITICISMS OF THE RESOURCES-ORIENTED VIEW

One of the criticisms of Rawls’ and Daniels’ resources-oriented view is that it lacks a focus on the results of the allocation of resources. By placing a moral weight on the resources alone, it fails to recognize health as an end itself. For if there is a fair distribution of the socially controllable factors affecting health and health is not achieved, according the Daniels, there is no violation of the right to health. Daniels states that health inequalities that derive from social determinants are unjust unless the determinants are distributed in conformity with the

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155 Id.
156 Justice and Access, supra note 18, at 29.
157 Justice, Health, and Healthcare, supra note 2, at 234.
158 Id.
160 Justice and Access, supra note 18, at 29.
principles he uses.\textsuperscript{161} Daniels even admits that the residual health inequalities that are left cannot be deemed just or unjust under the theory he utilizes.\textsuperscript{162}

In his evolution from a right to health care into a right to health, Daniels recognizes that social determinants have a significant impact on health. Yet, Daniels still argues that health care itself is special, because access to healthcare leads to health, which is necessary to provide fair equality of opportunity. Yet, Daniels may be taking for granted the link between health and health care.\textsuperscript{163} With his focus on the resources rather than the results, Daniels may be ignoring the possibility that, with scarce resources, investment into ameliorating social determinants of health rather than health care may move more individuals closer to their fair share of health.\textsuperscript{164}

The problem with emphasizing the right to health care and its impact on equal opportunity is that Daniels does not state which types of health care society is obligated to provide.\textsuperscript{165} This compels the critical observation of the limitless number of factors that limit opportunity.\textsuperscript{166} The resource-oriented view in general is criticized for the oversimplification on the demands of health equity by assuming that health is the result of justice.\textsuperscript{167} Again, Daniels concedes that within his equality of opportunity framework, the right to health embodies a confusion about the kind of thing which can be the object of a right claim.\textsuperscript{168} Therefore, the focus is on input that could lead to health, not whether health or health capability is actually achieved.\textsuperscript{169}

C. THE RESULTS-ORIENTED VIEW

\textsuperscript{161} \textit{Justice, Health, and Healthcare, supra} note 2, at 234.
\textsuperscript{162} \textit{Id.}
\textsuperscript{163} Sreenivasan, \textit{supra} note 22, at 235.
\textsuperscript{164} \textit{Id.}
\textsuperscript{165} Ruger, \textit{supra} note 159, at 284.
\textsuperscript{166} \textit{Id.}
\textsuperscript{167} \textit{Id.}
\textsuperscript{168} \textit{Justice and Access, supra} note 18, at 28.
\textsuperscript{169} Ruger, \textit{supra} note 159, at 284–85.
i. Jennifer Prah Ruger’s Capability Approach

Jennifer Prah Ruger has put forth the claim that the capability approach, and the focus on health capabilities, should be utilized to evaluate the equity and efficiency of health policy and law. Unlike the resources-oriented view proposed by Daniels, the capability view does not pronounce that a person or group is worse-off or well-off simply by assessing their access to health care or other primary goods. Rather, focus is placed on central health capabilities, for example, the capability to avoid premature mortality and address escapable morbidity. Attention to these capabilities would move toward ensuring certain important functionings up to a certain minimally adequate level, which gives them special significance over our obligation to guarantee non-central health capabilities. In applying the capability approach to health, Ruger sees people’s capability to flourish as an end of political activity and sees this framework as addressing questions of justice and efficiency that other approaches do not. For the capability approach can ascertain existing inequalities and deprivations in people’s capability to achieve good health, while distinguishing the policies that can ameliorate inequalities and deprivations effectively and efficiently.

1. The Foundation for a Right to Health in the Capability Approach

   a. Aristotle

The foundation for utilizing the capability approach with regard to a right to health starts with the theories of Aristotle. Aristotle states that the end that all political activity should strive for is human flourishing. This concept incorporates the idea of capability, because our social

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170 Id. at 286–87.
171 Id. at 287.
172 Id.
173 Id.
174 Id.
175 Id.
176 Id. at 288.
obligation requires distributing goods, services, and conditions sufficient to allow one to function well if they choose to.\textsuperscript{177} By the government doing their part to allow for human flourishing, the individual has the capability to achieve human functioning while maintaining the freedom to choose the life they want to lead.\textsuperscript{178} This makes clear the government’s role in distributive justice and the capability approach. While resources are important, they do not constitute appropriate ends. The resources’ ability to promote human functioning should be the primary goal of public policy.\textsuperscript{179}

In judging political arrangements, Aristotle recognizes that there are natural and social impediments to human flourishing as well. As such, the political systems can only be expected to equalize achievements to allow people a good life up to the maximum permitted by circumstances.\textsuperscript{180} Another element of Aristotle’s view is the acknowledgement that there are various ends for various actions.\textsuperscript{181} This justifies health as a primary objective of health policy, because health has both intrinsic and instrumental value.\textsuperscript{182} For health is both a good that people can enjoy for itself, and it enables people to manage and control their lives.

Aristotle’s contention that human flourishing must be defined in order to determine if a political system promotes it has created some controversy.\textsuperscript{183} Attempts to completely specify the list of functions that constitute human flourishing, such as the list created by Martha Nussbaum which is found below, have been met with concerns about whether human flourishing must be culturally defined.\textsuperscript{184} Yet, Ruger places less importance on this definition, instead focusing on

\textsuperscript{177} Id. at 288–89.
\textsuperscript{178} Id. at 289.
\textsuperscript{179} Id.
\textsuperscript{180} Id. at 290.
\textsuperscript{181} Id.
\textsuperscript{182} Id.
\textsuperscript{183} Id. at 290–91.
\textsuperscript{184} Id. at 291.
establishing important aspects of health and the practical policy solutions that support it.\textsuperscript{185} Finally, Aristotle provides guidance on proportional justice by instructing that one person’s agency cannot be sacrificed to improve another person’s functioning, even if that person falls short of normal functioning.\textsuperscript{186} Therefore, the government’s aim is to bring each individual’s health as close to an optimal level of functioning as is possible for them, without dropping the health of others below the normal range.\textsuperscript{187}

b. Martha Nussbaum

One of the main proponents of the capability approach, Martha Nussbaum, asserts that this approach to the priorities of development focuses not on preference satisfaction, but on what people are actually able to do and be.\textsuperscript{188} The emphasis is not on what a person is given or has available to them in terms of resources, but what their opportunities and liberties are.\textsuperscript{189} The core idea is that human beings is a dignified free being who should be able to shape their own life, ‘rather than being passively shaped or pushed around by the world.’\textsuperscript{190} Human dignity involves an idea of equal worth, and “this respect should not be abridged on account of a characteristic that is distributed by the whims of fortune.”\textsuperscript{191} A value of equal worth gives value to the ability of individuals to live a life in accordance with their own view of what is deepest and most important.\textsuperscript{192} As such, a person should have the capability to choose between an array of functions that are accessible to them.

With this idea in mind, and following Aristotle’s view that human flourishing should be defined, Nussbaum set out to create a list of necessary elements of human functioning that would

\textsuperscript{185} Id.
\textsuperscript{186} Id. at 293.
\textsuperscript{187} Id. at 293.
\textsuperscript{189} Id. at 233.
\textsuperscript{190} Id. at 234.
\textsuperscript{191} Id. at 227.
\textsuperscript{192} Id.
be accepted across cultural barriers and endorsed by people who have varying ideas of what constitutes a good life.\textsuperscript{193} For the purposes of my paper, as Ruger put it, the emphasis is on a framework for establishing important aspects of health, “not a resolution to the definitional question of what human flourishing or health are.”\textsuperscript{194} However, it may be worth noting that all items on the list are interconnected and, at the same time, independently important and distinct in quality.\textsuperscript{195} Due to their separation and connection to each other, one cannot be replaced by another.\textsuperscript{196} Also relevant is Nussbaum’s assertion that the list illustrates that to be able to fully develop the essential human functions, the proper educational and material support must be provided.\textsuperscript{197}

The three types of capabilities are basic capabilities, internal capabilities, and combined capabilities.\textsuperscript{198} The basic capabilities are innate equipment of individuals necessary for developing more advanced capabilities, such as practical reasoning and imagination.\textsuperscript{199} Internal capabilities are the states of the person that are sufficient conditions for the exercise of the

\textsuperscript{193} \textit{Id.} at 234–35. The list includes ten central human functional capabilities: (1) Life – not dying prematurely, or before one’s life is so diminished to not be worth living; (2) Bodily health – being able to have good health, including reproductive health, to be adequately nourished, to have adequate shelter; (3) Bodily integrity – being able to move freely from place to place, secure against assault, having opportunities for sexual satisfaction, and for choice in reproductive choices; (4) Senses, imagination, and thought – being able to use senses, imagine, think, and reason, including adequate education, freedom of expression, speech, religion, and avoiding non-necessary pain; (5) Emotions – being able to have attachments to things and people outside ourselves, and not having emotional development blighted by fear and anxiety; (6) Practical Reason – ability to form a conception of the good and to engage in critical reflection about the planning of one’s life, protecting the liberty of conscience; (7) Affiliation – (a) ability to live with and toward others in various forms of social interaction, capability for justice and friendship, protecting institutions that constitute and nourish affiliation, and the freedom of assembly and political speech; (b) having social bases of self-respect and non-humiliation, protecting against discrimination of race, religion, sex, sexual orientation, caste, ethnicity, or national origin; (8) Other species – ability to live with concern for and in relation to animals, plants, and nature; (9) Play – able to laugh, play, and enjoy recreational activities; and (10) Control over one’s environment – (a) political – ability to participate effectively in political choices that govern one’s life, having the right of political participation, protecting free speech and association; (b) material – ability to hold property, both land and movable goods, right to seek employment equally, and freedom from unwarranted searches and seizures.

\textsuperscript{194} Ruger, \textit{supra} note 159, at 291.

\textsuperscript{195} Nussbaum, \textit{supra} note 188, at 236.

\textsuperscript{196} \textit{Id.}.

\textsuperscript{197} \textit{Id.}

\textsuperscript{198} \textit{Id.} at 237.

\textsuperscript{199} \textit{Id.}
requisite functions; for example, most adults have the internal capability for religious freedom and freedom of speech. Nussbaum’s list of central capabilities is made of combined capabilities because they require not only internal capabilities, but suitable external conditions to make it possible to exercise the requisite functions.

The capability approach relates to the right to health, and human rights in general, in that it provides the philosophical foundation for basic constitutional principles. To secure a right to a citizen in a certain area is to put them in a position of capability to function in that area. As seen in the description of combined capabilities, this means more than stating that someone has a certain right. For example, the right to vote was given to minorities and, yet, for years devices such as literacy tests were utilized to prevent them from actually voting. This example exhibits the main difference between describing rights and capabilities. While a black person may have been given the right to vote, they were not provided with the required environment to actually utilize that right, a requirement of the capability to vote. Defining rights in terms of capabilities makes it clear that a person does not have the right simply because they are told they do, but because effective measures are taken to ensure they are truly capable of exercising that right.

c. **Amartya Sen**

Similar to Nussbaum, Amartya Sen also utilizes the capability approach, which is connected to Aristotle’s social and political ethics. Sen emphasizes the importance of recognizing the internal and external characteristics affecting one’s life to properly gauge

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200 Id.
201 Id.
202 Id. at 239.
203 Id. at 240.
equality. This is an example, similar to Nussbaum’s approach, of a distinguishing factor from the resources-oriented approach, which fails to consider the different effects the same goods can have on different people. By emphasizing one’s capability as the focus for social evaluation, Sen maintains the importance of allowing individuals the freedom to choose the life they want given their circumstances.

This freedom involves an evaluation in two senses: opportunity and process. Through the lens of opportunity, a health policy is assessed on its ability to impact individuals’ health capabilities and functionings. Through the process aspect, a health policy is required to have direct, instrumental, and constructive public participation, with an open discussion to help understand needs and formulate appropriate solutions. This helps to ensure that the public has input in what the public health problems are, as well as affecting the solutions to these problems.

To be able to properly evaluate a health policy, the public must also participate in the selection and valuation of capabilities to determine what health functionings are most important. Again, this valuing of capabilities is what differentiates this approach from one that focuses on the means to achieving these capabilities. Sen’s notion of basic capabilities are those required by justice to be provided, along the lines of Daniels’s basic minimum. However, Sen concentrates on achieving those basic capabilities rather than the resources that should lead to them. Focusing on achieving a consensus in identifying and prioritizing the most valued capabilities and means to achieve them, the capability approach allows for incomplete

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204 Ruger, supra note 159, at 296.
205 Id.
206 Id. at 293.
207 Id. at 297.
208 Id.
209 Id. at 298.
210 Id. at 298–99.
211 Id. at 299.
specification. Thus, certain capabilities, such as premature mortality and escappable morbidity, can be universally accepted goals even though others are left unspecified.

Likewise, dominance partial ordering allows for certain health capabilities to be deemed of value without determining up front which are more valuable. This is important for health policy evaluation because if it is unnecessary to choose a freedom from one disease over another, then there is no need to decide which is more important initially. Partial agreements separate useful, agreed upon solutions from unacceptable ones initially, and then allow for a determination of how to incorporate the valued freedoms into public policies.

2. Incompletely Theorized Agreements

When partial ordering and incomplete specification are unable to provide reasonable policies that resolve disagreements over differing views, incompletely theorized agreements (ITAs) can help alleviate the problem. An ITA is an agreement that is not uniformly theorized from high level justification to low level particulars, yet, answers the question of what type of social decision making might apply to obtain collective agreement on a dominance partial ordering of capabilities. ITAs are significant to the right to health because they allow for health policies to be agreed upon without consensus on the underlying theory of why it is important. This allows for concrete action for human goods that are plural and ambiguous, such as health.

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212 Id.
213 Id. at 300.
214 Id.
215 Id.
216 Id. at 301.
217 Id. at 304. Three types of ITAs: (1) incompletely specified agreements – agreement on a general principle but disagreement about particular cases; (2) incompletely specified and generalized agreements – agree on mid-level principle, but not about more general theory accounting for it and about outcomes in particular controversies; (3) incompletely theorized agreements on particular outcomes – people agree on low-level principles that do not necessarily derive from one high-level theory.
218 Id. at 309.
Different people will have differing views on what health and health capabilities are, nevertheless, ITAs compliment the capability approach and its application in the right to health by allowing for these differing views to converge into a useful health policy. This permits people to agree that health and health capabilities are essential without agreeing on, or even knowing, why they are essential. This compliments Sen’s dominance partial ordering because there can be agreement on certain health capabilities without politicians agreeing completely on all central health capabilities.

3. The Right to Health

When making a case for a right to health there needs to be a useful idea of what health is, to guide the implementation of this right. If the right to health is too broad it is less likely to have a meaningful effect due to a lack of clear content. A clear and acceptable concept of health is necessary to allow for appropriate comparisons. Attempting to identify certain central agreed upon features of health, Ruger suggests the following model of health:

(1) The state of the organism when it functions optimally without evidence of disease or abnormally. (2) A state of dynamic balance in which an individual’s or a group’s capacity to cope with all the circumstances of living is at an optimum level. (3) A state characterized by anatomic, physiologic, and psychologic integrity, ability to perform personally valued family, work, and community roles, ability to deal with physical, biologic, psychologic, and social stress; a feeling of well-being; and freedom from the risk of disease and untimely death.

Ruger finds this model useful because it includes physical and mental states while recognizing the social aspect of humans. Furthermore, this definition fits well within the capability approach because it recognizes both potential health as well as actual health, respecting the

219 Id. at 309–310.
220 Id. at 310.
221 Id. at 311.
222 Id. at 312.
223 Id.
224 Id.
225 Id. at 316.
226 Id.
freedom of individuals to pursue the opportunities for optimal health through the health functions that are available to them.\textsuperscript{227}

To transform this right to health into legislative changes, there needs to be an ethical commitment to a social organization that redistributes resources with the end goal of providing the capability for all to be healthy.\textsuperscript{228} Under the capability approach, the right to health obligation of resource redistribution refers to interests in individuals’ capabilities and functionings, not preferences and desires.\textsuperscript{229} Compelling institutional change is more likely to occur when individuals internalize the public moral norm that health is worthy of social recognition, investment, and regulation.\textsuperscript{230}

In the hopes of obtaining equality in health, not only is a definition of health necessary, but a way to gauge equality in terms of capability is essential as well. Ruger employs shortfall equality, which compares shortfalls of actual achievement from the optimal average to measure, in part because difficulty of assessing health capabilities by equalizing achievements for different people.\textsuperscript{231} Additionally, shortfall is useful in that it can be measured in absolute or proportional terms, allowing for appropriate measurements of health for people with disabilities or those in developing countries.\textsuperscript{232}

This approach’s ability to assess health policy and the end goal of health includes the assumption that good health or equal health for everyone is impossible to guarantee.\textsuperscript{233} It also can evaluate a health policy by comparing the achievements of the policy with estimates of what

\textsuperscript{227} Id. at 317.
\textsuperscript{228} Id. at 318.
\textsuperscript{229} Id.
\textsuperscript{230} Id. at 318–19.
\textsuperscript{231} Id. at 320.
\textsuperscript{232} Id.
\textsuperscript{233} Id.
should be possible, the health potential.\textsuperscript{234} Using this comparison, the government has the responsibility to determine how to prioritize resources in order to close the gap between that potential and the actual achievements of the health policy. For example, a high prevalence of preventable death and disease, such as high rates of AIDS, malaria, or tuberculosis, implies that the health policies and health sector were falling short of their obligation.\textsuperscript{235}

Another measuring tool is the proportion of shortfall reduced, which can quantify a country’s progress toward raising health capabilities to certain levels.\textsuperscript{236} The example Ruger uses is life expectancy. When the target life expectancy is 81 years, a shortfall is reduced by a larger proportion when a country’s life expectancy goes from 60 to 70 years than when it changes from 30 to 40 years.\textsuperscript{237} Reducing a 21-year shortfall by 10 years is certainly more beneficial to the population than the same reduction in a 41-year shortfall. This same tool can be applied to an individual level by assessing the maximal potential functioning and reducing the gap or shortfall between that and the person’s actual functioning.\textsuperscript{238} This shows that the goal of utilizing a capability approach to a right to health is to minimize, if not eliminate, health inequalities for both individuals and groups, therefore, increasing the ability to achieve health-related functionings.

D. CRITICISMS OF THE CAPABILITY APPROACH

While the capability approach avoids the problem of being too narrow, one of the complaints regarding the resources-oriented view, it is criticized as being too broad. Some feel that the approach needs to be specified in order to inspire original applications.\textsuperscript{239} With

\textsuperscript{234} Id. at 321.
\textsuperscript{235} Id.
\textsuperscript{236} Id.
\textsuperscript{237} Id.
\textsuperscript{238} Id.
capabilities pertaining to what a person is capable of doing, rather than what they are actually able to do, it becomes difficult to assess the potentiality incorporated into this approach.\textsuperscript{240} While functionings are important to the capability approach, the goal is to provide a person with many potential functions to provide them with a deserved capability set. Yet, it is a functioning, specifically actually achieved functioning, that is more easily measured. Furthermore, the capability approach has been criticized for its inability to provide a properly defined and valued system of capabilities, since not all capabilities can be considered equally valuable.\textsuperscript{241}

The capability approach, specifically that conveyed by Ruger, addresses these criticisms in different ways. First, the approach is meant to be broad to allow for a broad application to not only health, which is specifically addressed in this paper, but to voting rights, education, employment, and numerous other issues this country hold as vital to the American experience. This broad applicability further allows the implementation of the approach to span the globe, leaving it the freedom to be adapted into various cultures that may hold different ideals about what is imperative to the human experience.

At the same time, as seen with Nussbaum’s list, the approach does not leave open the possibility that any culture can simply disregard certain essential human capabilities by claiming they are not valued in that specific region. While some may criticize Nussbaum’s list, for example the inclusion of play or other species into her list, recreational freedom and the freedom to interact with nature should be available to all persons. For example, a woman that is kept indoors and zealously guarded since infancy, married at age six, and forbidden to engage in imaginative exploration, will be prevented from both the internal and external capability to

\textsuperscript{240} Id. at 24.
\textsuperscript{241} Id.
play. This is significantly different than the woman who chooses to work long hours and has little interest in recreation. In the health application of the capability approach, Ruger attempts to assuage the problem of broadness by clearly defining an acceptable model of health to give health policies a clear objective to strive for. Furthermore, Ruger’s operation of shortfall equality ensures that even a vague term such as equality can be appropriately measured.

The criticism of an inability to assess someone’s capabilities holds significantly less weight when the capability approach is applied to the realm of health. Unlike the resources-oriented approach, the capability approach looks at whether actual health capabilities were achieved. If a person dies prematurely, it can easily be determined what they died of. Malnutrition, AIDS, cancer, car crash, and a gun shot all tell a different story. Preventable death is a health indicator that is frequently utilized to assess a population’s health and it is extremely useful when determining not only an individual’s capabilities, but a country’s ability to provide central health capabilities as well. And while every citizen’s complete health capabilities may not be accurately measured and documented, the goal of a right to health and utilizing the capability approach with public health problems is to have a wide-ranging impact. The same health indicators that are used to determine that the United States ranks low in health globally can be employed to determine if the health capabilities of the country are improving due to certain health policies.

The need to define, value, and weight all capabilities is addressed by Ruger with her utilization of partial ordering, incomplete specification, and incompletely theorized agreements. Not every health capability worth addressing must be clearly specified up front. Agreement can be made on reducing premature mortality and escapable morbidity, while other

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242 Nussbaum, supra note 188, at 238 (stating that girls in rural Rajasthan have great difficulty learning to play because their capacity for play has not been nourished early in childhood).

243 See supra Part III(c)(i)(1)(c)
capabilities are left undetermined. And when certain capabilities are universally accepted as worthy of addressing, partial ordering allows for them to be deemed valuable without deciding which is more valuable. When policies cannot be made with the use of incomplete specification and partial ordering, incompletely theorized agreements can resolve disputes. The incompletely theorized agreements allows for resolutions about policies to be made without necessarily agreeing on the valuing and weighting of all potential health capabilities. If an agreement can be made that the capability to receive health insurance is important, there is no need to agree on whether it is essential due to its ability to reduce costs or because justice demands it. Different views on what health and health capabilities are can still lead to implementation of health policies through incompletely theorized agreements, making the need to define, value, and weight health capabilities less important.

E. APPLICATION OF THE CAPABILITY APPROACH TO SOCIAL DETERMINANTS OF HEALTH

To ensure that central health capabilities exist, health policies must address the social determinants of health. Since medical services make up 10 to 15 percent of the contribution to reducing premature death, even universal health care will leave behind disparities in health.\(^\text{244}\) Low socioeconomic status, low educational attainment, low-wage jobs, poor-quality housing, and polluted and dangerous neighborhoods all play a major role in a person’s health. Yet, public policy can shape one’s environment through behavioral change or structural change.\(^\text{245}\) Here I will briefly examine a few of these social determinants, how they affect health, and how the capability approach requires they be addressed.

i. Prenatal Care

\(^{244}\) Blacksher, supra note 10, at 28.
\(^{245}\) Social Determinants of Health: The Solid Facts – in Ethical Issues in Modern Medicine, in ETHICAL ISSUES IN MODERN MEDICINE 213, 213 (Bonnie Steinbock, Alex John London & John D. Arras eds., 2009).
If there are severe health problems once a child is born, neonatal intensive care
technology can do a lot to alleviate those problems and reduce infant mortality.\textsuperscript{246} But while this
high quality and readily available technology is helpful, the risk for prematurity or prenatal death
is mostly related to the internal and external characteristics of the birth mother.\textsuperscript{247} While women
may have the right to become pregnant and give birth to a child, they must also be given the
capability to deliver as healthy a child as possible. To effectively reduce infant mortality,
prenatal care must be addressed in a more proactive manner. Not only will a pregnant woman’s
income and educational levels affect her unborn child, but so will a lack of prenatal information
and services, poor nutrition and sanitation, and exposure to toxins through smoking, alcohol,
drugs, and environmental pollutants.\textsuperscript{248}

\textit{ii. Early Childhood Education}

Investment in public education is extremely important because education is not only
linked to future employment and political participation, but it is directly linked to health as well.
In fact, adult literacy is one of strongest predictors of life expectancy.\textsuperscript{249} An international
example would be the poor state of Kerala in India, which invested heavily in education,
especially female literacy, and now has health outcomes far superior to the rest of India.\textsuperscript{250}
Similarly, reading levels and drop-out rates in the United States have an immediate impact on
health, increasing the likelihood of premature death during childhood and adolescence.\textsuperscript{251}

Early childhood education is particularly important, as this is where the foundation is laid
for health in adulthood. Good health-related habits, including eating, not smoking, and physical

\textsuperscript{246} Ruger, \textit{supra} note 159, at 285.
\textsuperscript{247} \textit{Id.}
\textsuperscript{248} \textit{Id.}
\textsuperscript{249} Justice, \textit{Health, and Healthcare, supra} note 2, at 233.
\textsuperscript{250} \textit{Id.} at 232.
\textsuperscript{251} \textit{Id.} at 233.
activity, are created in one’s youth, and these are closely associated with education. Simply investing more money into education, as politicians often promise to do, does not necessarily equate to the students having the capability to learn. They must be provided with an environment conducive to learning, which includes qualified teachers and freedom from fear of violence, as well as sufficient learning materials.

iii. Employment

Whether or not a person has a job, and if so, the environment they have at that job, affects one’s health in various ways. Aside from the obvious connection to income, jobs and job security are linked to anxiety, which can have drastic effects on an individual’s mental health, self-reported ill health, heart disease, and risk factors for heart disease. Evidence suggests that unemployment can also have an impact on work motivation, skill and self-confidence, potentially digging a perpetuating whole of unemployment that could be difficult to escape from. Meanwhile, unemployment can impact the health of one’s family as well as themselves, with both seeing an increased risk of premature death.

Yet, those with jobs can feel the effects of not having job control, which may produce stress-induced damages. Job control refers to an individual’s level of task control in the workplace and when there’s low job control, resulting in high stress levels, there can be an increased risk of coronary heart disease. Furthermore, there is a connection between job

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253 Social Determinants of Health: The Solid Facts – in Ethical Issues in Modern Medicine, in ETHICAL ISSUES IN MODERN MEDICINE 213, 218 (Bonnie Steinbock, Alex John London & John D. Arras eds., 2009). The mental health effects include anxiety itself as well as depression.
256 Gopal Sreenivasan, Justice, Inequality, and Health, STANFORD ENCYCLOPEDIA OF PHILOSOPHY 1, 9 (Spring 2009) http://plato.stanford.edu/entries/justice-inequality-health/.
257 Id.
control and occupation rank. This is important because the social gradient in health can be noticed even among those within the same social class who have differing occupational ranks. Lower ranking staff suffer much more disease and earlier death than higher ranking staff. To reduce stress levels, individuals must be capable of not only obtaining employment, but be provided with a working environment that allows them to be free to perform and enjoy their job as much as circumstantially possible.

iv. Income Distribution

Income distribution may be the most apparent and influential social determinant of health because it permeates through the other social determinants as well as having an impact on its own. The United States already seeks to address this issue with a progressive tax system. Yet, countries with more equal income distributions than the United States have higher life expectancy, even if they have a lower per capita Gross Domestic Product (GDPpc). Even in states within the United States, income inequality accounts for approximately 25% of the between-state variation in age-adjusted mortality rates. Experiencing relative poverty can deny people access to decent housing, as well as a good education, and can severely affect a person’s ability to be healthy. The poor often have little to no access to healthy foods and are more likely to be exposed to violence. At this country’s current state, not only can income affect one’s ability to obtain medical treatment and access health care, but it can affect an individual’s ability to achieve the health capabilities they seek.

v. The Capability Approach Applications and the Negative Constitution

258 Id.
260 Justice, Health, and Healthcare, supra note 2, at 233.
These examples further illustrate the ability to implement the capability approach and recognize a right to health without deteriorating the preexisting notion of the negative Constitution. The applications of the capability approach that are given are examples of issues that the government already seeks to address. Measures have been taken by the government to improve certain people’s quality of life and afford them as equal an opportunity as possible to live the lives they choose. Therefore, the claim is not for an affirmative right to any service that is not currently available. Nor is there a claim that the government is obligated to cure some social ill that it is not already currently working to address. The capability approach merely states that the measurements taken related to these issues must in actuality provide the ability to live the life that one chooses. In order to do this, this paper argues, the actions taken must be improved to have the impact that they are supposedly already in place to make.

IV. CONCLUSION

As shown throughout this paper, the many issues facing the United States can all be linked to health in some form. National debt, high unemployment rate, poor public education, and an inefficient workforce can all be connected to an unhealthy nation that spends an exceeding amount of money on trying to be healthy. To address the country’s health problems, the solutions must come from the public health realm. Decreasing preventable death and escapable morbidity, and increasing life expectancy can be accomplished with population based solutions. But the government is the only entity with the resources and authority to tackle these broad issues.

The capability approach fits well within the public health spectrum because of its respect for the freedom of choice. It allows for the government to utilize its power granted to it by the people to enforce policies that can have a wide-ranging affect. Yet, with its respect for
autonomy, the capability approach will prevent the government from abusing its power by permitting individuals to choose from the alternative functions that are available to them. An American should be free to exercise their choice to fast, though none should ever be forced to starve. Likewise, in the country that spends the most on its health system, no American should suffer from preventable health disparities.

The capability approach offers a unique approach to this problem in that it does not only suggest that improving one’s health would improve their capabilities, it also allows for the possibility to improve one’s health by improving their other capabilities. So, if one’s health capabilities can be improved by ensuring they have education or employment capabilities, why argue for a right to health? It may be hard to argue that a person has a right to a particular job or income, or that society is obligated to send them to a particular school. Yet, most would be understanding of the right to be free from preventable disease and injury. This may seem unlikely, given the United States’ failure to recognize the right to health in general, but the recent push for universal health care, while not a solution by any means, does give evidence that the societal approach to health is changing.

By addressing all social problems from a health perspective, policies improving individuals’ health capabilities will result in improving the rest of the capabilities essential for human flourishing as well. Health is a prerequisite to all capabilities. By focusing on improving the health of the population, consequently, individuals will have the capability to pursue a better education, perform better at their job, or enjoy one’s life more. Not only does addressing health capabilities improve the opportunities for individuals to make for themselves a better lot in life, but as seen in the 1800s with the Germans, a healthier population makes a stronger, more efficient nation that everyone can benefit from. In this sense, the right to health argument, and
the capability approach’s ability to give guidance on its implementation, allows for an approach to improving all social ills in terms that may, and should, be acceptable to all Americans.