

Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements

Jennifer Prah Ruger*

INTRODUCTION

One would be hard pressed to find a more controversial or nebulous human right than the “right to health”—a right that stems primarily, although not exclusively, from Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) and requires governments to recognize “the right of everyone to the highest attainable standard of physical and mental health.”¹ While activists, non-governmental organizations, and scholars have made significant progress in promoting a human rights approach to health and the field of health and human rights more generally,² the question of a philosophical and conceptual foundation—a theory—for the right to health has fallen through the cracks that emerge from an interdisciplinary intersection of medical ethics, international relations, international human rights law,

* Assistant Professor, Yale University, School of Medicine and Graduate School of Arts and Sciences, and School of Law (Adjunct); Ph.D. Harvard University 1998; M.Sc. Oxford University, U.K. 1992; A.B. University of California-Berkeley 1988. I thank Amartya Sen, Jerry Green, Joseph Newhouse, Cass Sunstein, Jane Mansbridge, Allan Brandt, Sudhir Anand, Milton Weinstein, Marion Danis, Ezekiel Emanuel, Theodore Ruger, William Hogan, and Alvin Tarlov as well as participants in seminars and workshops at Harvard University and Trinity College, University of Cambridge, for helpful comments on earlier versions of this work; Gwendolyn Bradford, Benjamin Gould, Hans Leaman, and Betsy Rogers for helpful editing assistance; and Christine Park for research assistance. This paper is drawn in part from my doctoral dissertation at Harvard University entitled *Aristotelian Justice and Health Policy: Capability and Incompletely Theorized Agreements*, 1998, supervised by Amartya Sen, Joseph Newhouse, and Jerry Green. For research support, I thank the Health Institute, the Henry J. Kaiser Family Foundation, the National Library of Medicine (NIH), the Mark DeWolfe Howe Fund, and the Brookings Institution.

1. International Covenant on Economic, Social and Cultural Rights, Dec. 19, 1966, 993 U.N.T.S. 3. The right to health is also expressly recognized in Article 25 of the Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/810 (1948), in the International Covenant on Civil and Political Rights, Dec. 19, 1966, 999 U.N.T.S. 171, as well as in other international legal instruments.

2. See, e.g., George J. Annas, *The Right to Health and the Nevirapine Case in South Africa*, 348 NEW ENG. J. MED. 750 (2003); Sofia Gruskin & Daniel Tarantola, *Health and Human Rights* (2001); Jonathan M. Mann et al., *Health and Human Rights*, 1 HEALTH & HUM. RTS. 6 (1994); PAUL FARMER, *HEALTH, HUMAN RIGHTS, AND THE NEW WAR ON THE POOR* (2003).

health policy, health law, and public health law.

International human rights law scholars working in public health and health policy have typically focused on government's binding legal obligations to promote and protect both public health and human rights.³ They have drawn on human rights to address public health issues, especially the HIV/AIDS pandemic.⁴ Although scholars in this field have, in the words of one academic, "developed a sophisticated understanding of civil and political rights," they "have failed systematically to examine the meaning and enforcement of social and economic rights."⁵ And while General Comment No. 14, issued by the UN Committee on Economic, Social, and Cultural Rights (CESCR), provides the most reliable report on the right to health, it too, by necessity and purpose, lacks a systematic philosophical grounding for the right to health.

The few international relations scholars and practitioners who do focus on health issues have provided primarily three dominant frameworks for international health cooperation: national and security interests; domestic and global economic development; and international human rights.⁶ Human rights approaches have filled a "moral gap" in the international global health discourse left primarily by economic and geo-political governance frameworks for international health issues. But the human rights strategy has been only moderately effective, for example in efforts to control and mitigate the HIV/AIDS epidemic⁷ and to implement the constitution of the World Health Organization (WHO). Furthermore, international relations as an academic discipline has not focused on providing a theory—based in moral and political philosophy—of a right to health.

3. See Annas, *supra* note 2; Jonathan M. Mann, *Health and Human Rights*, 312 BRIT. MED. J. 924 (1996). See also the Canadian Supreme Court decision on the right to health in *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791.

4. David P. Fidler, *Fighting the Axis of Illness: HIV/AIDS, Human Rights, and U.S. Foreign Policy*, 17 HARV. HUM. RTS. J. 99 (2004); Jonathan M. Mann, *Human Rights and AIDS: The Future of the Pandemic*, in HEALTH AND HUMAN RIGHTS 216 (J.M. Mann et al. eds., 1999).

5. Lawrence O. Gostin, *The Human Right to Health: A Right to the "Highest Attainable Standard of Health"*, HASTINGS CTR. REP., Mar.-Apr. 2001, at 29, 29-30; see also Steven D. Jamar, *The International Human Right to Health*, 22 S.U. L. REV. 1 (1994); Virginia A. Leary, *The Right to Health in International Human Rights Law*, 1 HEALTH & HUM. RTS. 24 (1994). On skepticism of economic and social rights more generally, see MICHAEL IGNATIEFF, HUMAN RIGHTS AS POLITICS AND IDOLATRY (2001); ONORA O'NEILL, TOWARDS JUSTICE AND VIRTUE: A CONSTRUCTIVE ACCOUNT OF PRACTICAL REASONING (1996); Maurice Cranston, *Are There Any Human Rights*, 112 DAEDALUS 1 (1983); and Frank B. Cross, *The Error of Positive Rights*, 48 UCLA L. REV. 857 (2001). On support for economic and social rights, see STEPHEN HOLMES & CASS SUNSTEIN, THE COST OF RIGHTS (1999); and Frank I. Michelman, *What (If Anything) Is Progressive-Liberal Democratic Constitutionalism?*, 4 WIDENER L. SYMP. J. 181, 199 (1999).

6. See Fidler, *supra* note 4; Ilona Kickbusch, *Global Health Governance: Some Theoretical Considerations on the New Political Space*, in HEALTH IMPACTS OF GLOBALIZATION: TOWARDS GLOBAL GOVERNANCE 192 (Kelley Lee ed., 2003); Gill Walt, *Global Cooperation in International Public Health*, in INTERNATIONAL PUBLIC HEALTH: DISEASES, PROGRAMS, SYSTEMS, AND POLICIES 667 (Michael H. Merson et al. eds., 2001).

7. Fidler, *supra* note 4.

By far one of the most important scholarly realms bearing on the grounding of a right to health is medical ethics or bioethics. Existing frameworks in medical ethics, even those that include health assessment, have typically justified health care as a special social good. They have paid less attention, however, to universal concerns of social justice with respect to health itself.⁸ This bias seems to stem from at least one assumption: that health is not an appropriate focal variable for assessing social justice or human rights, whereas utilities, community values, liberties, opportunities, resources, and primary goods are. As Norman Daniels argues, “Health is an inappropriate object, but health care, action which promotes health, is appropriate.”⁹ He emphasizes that “a right claim to equal *health* is best construed as a demand for equality of access or entitlement to health *services*”¹⁰ Kristen Hessler and Allen Buchanan recently reiterated this view, stating that a “*right to health care* implies, on its face, a right to certain services; by contrast, a *right to health* seems to imply a right to be healthy, which is an impossible standard.”¹¹ Such reasoning illustrates the strong bias against health as a focal variable in current ethical frameworks.¹² The focus on health care suggests that the major inequity in domestic and international health is differential access to care, not differences in health.¹³ This emphasis has left scholars unspoken on the philosophical foundations of health and its distribution.

And to the extent that the fields of health law and public health law address human rights at all, they do so by emphasizing civil and political rights, or by focusing on legal instruments (laws, regulations, court decisions)¹⁴ that affect the health care¹⁵ and public health systems.¹⁶ In the

8. Jennifer Prah Ruger, *Health and Development*, 362 LANCET 678 (2003) [hereinafter Ruger, *Health and Development*]; Jennifer Prah Ruger, *Aristotelian Justice and Health Policy: Capability and Incompletely Theorized Agreements* (Jan. 7, 1998) (unpublished Ph.D. dissertation, Harvard University) (on file with Harvard Archives, Harvard University) [hereinafter Ruger, *Aristotelian Justice*]; Jennifer Prah Ruger, Presentation at the Doctoral Seminar in Health Policy, Harvard University: Social Justice and Health Policy: Aristotle, Capability and Incompletely Theorized Agreements (Nov. 25, 1997) [hereinafter Ruger, *Justice and Health Policy*].

9. NORMAN DANIELS, *JUST HEALTH CARE* 6 (1985).

10. *Id.* at 7.

11. Kristen Hessler & Allen Buchanan, *Specifying the Content of the Human Right to Health Care*, in *MEDICINE AND SOCIAL JUSTICE: ESSAYS ON THE DISTRIBUTION OF HEALTH CARE* 84, 85 (Rosamond Rhodes et al. eds., 2002).

12. Jennifer Prah Ruger, *Health and Social Justice*, 364 LANCET 1075 (2004).

13. Dan Brock, *Broadening the Bioethics Agenda*, 10 KENNEDY INST. ETHICS J. 21 (2000); Timothy Evans et al., *Introduction*, in *CHALLENGING INEQUITIES IN HEALTH: FROM ETHICS TO ACTION 2* (Timothy Evans et al. eds., 2001).

14. See, for example, the Canadian Supreme Court decision *Chaoulli v. Québec (Attorney General)*, [2005] 1 S.C.R. 791, as discussed in Theodore W. Ruger, *The United States Supreme Court and Health Law: The Year in Review*, 33 J.L. MED. & ETHICS 611 (2005), and the South African Supreme Court decision, *Soobramoney v. Minister of Health* 1998 (1) SA 765 (CC), as discussed in Annas, *supra* note 2.

15. See, e.g., MARK HALL ET AL., *HEALTH CARE LAW AND ETHICS* (6th ed. 2003); M. Gregg Bloche, Comment, *Trust and Betrayal in the Medical Marketplace*, 55 STAN. L. REV. 919 (2002).

16. LAWRENCE O. GOSTIN, *PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT* (2002).

United States, in particular, health law has generally focused on two main categories. One includes laws regulating government-run programs like Medicaid, Medicare, and the Veterans Administration and Federal Employees programs. The other encompasses laws regulating private sector health insurance (e.g., managed care organizations) and provider groups (including pharmaceutical companies). Although public health law practitioners have worked diligently to advance a human rights approach to public health,¹⁷ this work has taken place primarily at a policy and court case level, leaving philosophical issues unaddressed.

Finally, traditional health policy analysis has often focused more on the *means* to health—questions of the organization, financing and delivery of medical care—than on health itself.¹⁸ In traditional health policy, for example, the focus on health as an objective has had to compete with other priorities, such as (1) financing and organizing medical insurance;¹⁹ (2) organizing and delivering medical care services;²⁰ (3) physician supply and payment and the quality of medical care;²¹ and (4) financing, distributing, and regulating pharmaceuticals.²² And health economics as a discipline has devoted far more attention to the economics of medical care than to the subject of the economics of health as such.²³ While it is

17. *See id.*

18. *See, e.g.,* HEALTH SERVICES RESEARCH: KEY TO HEALTH POLICY (Eli Ginzberg ed., 1991); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982); THEDA SKOCPOL, BOOMERANG (1996). Also in developing countries, the focus in health policy has primarily been on health care. *See* WORLD BANK, WORLD DEVELOPMENT REPORT: INVESTING IN HEALTH (1993).

19. *See* Health Security Act, H.R. 3600, 103d Cong. (1993); STARR, *supra* note 18; Stuart H. Altman & Ellen K. Ostby, *Paying for Hospital Care: The Impact on Federal Policy*, in HEALTH SERVICES RESEARCH, *supra* note 18, at 46; Karen Davis & Diane Rowland, *Financing Health Care for the Poor*, in HEALTH SERVICES RESEARCH, *supra* note 18, at 93; Harold S. Luft, *How Do Health Maintenance Organizations Achieve Their "Savings"?* *Rhetoric and Evidence*, 298 NEW ENG. J. MED. 1336 (1978).

20. *See* Alain C. Enthoven, *Managed Competition: An Agenda for Action*, 7 HEALTH AFF. 25 (1988).

21. *See* Robert H. Brook et al., *Quality of Ambulatory Care: Epidemiology and Comparison by Insurance Status and Income*, 28 MED. CARE 392 (1990); Paul D. Cleary & Elizabeth Davies, *Hearing the Patient's Voice: Factors Affecting the Use of Patient Survey Data in Quality Improvement*, 393 QUALITY & SAFETY HEALTH CARE 14 (2005); Paul B. Ginsburg & Philip R. Lee, *Physician Payment*, in HEALTH SERVICES RESEARCH, *supra* note 18, at 69; Uwe Reinhardt, *Health Manpower Forecasting: The Case of Physician Supply*, in HEALTH SERVICES RESEARCH, *supra* note 18, at 234.

22. *See, e.g.,* PATRICIA DANZON & JEONG KIM, OFFICE OF HEALTH ECON., THE LIFE CYCLE OF PHARMACEUTICALS: A CROSS-NATIONAL PERSPECTIVE (2002), <http://hc.wharton.upenn.edu/danzon/PDF%20Files/OHE%20Life%20Cycle%20full%20book.pdf>.

23. In the field of health economics, focus on the economics of health *per se* has been pursued by a limited number of scholars who have studied health as a function of medical care, age, income, education, sex, race, marital status, environmental factors, and individual behaviors such as smoking, exercise, diet, and alcohol consumption, including VICTOR R. FUCHS, THE FUTURE OF HEALTH POLICY (1993); Richard Auster et al., *The Production of Health, an Explanatory Study*, 4 J. HUM. RES. 411 (1969); Marilyn C. Bergner & J. Paul Leigh, *Schooling, Self-Selection, and Health*, 24 J. HUM. RES. 433 (1989); Angus Deaton & Christina Paxson, *Aging and Inequality in Income and Health*, 88 AM. ECON. REV. & PROC. 248 (1998); Phillip Farrell & Victor R. Fuchs, *Schooling and Health: The Cigarette Connection*, 1 J. HEALTH ECON. 217 (1982); Donald S. Kenkel, *Health Behavior, Health Knowledge, and Schooling*, 99 J. POL. ECON. 287 (1991); and Michael Grossman, *The Demand for Health: A Theoretical and Empirical Investigation* (National Bureau of Economic Research

important to deal with these health policy issues in terms of means, the ultimate end, as I will argue in what follows, is health and human flourishing.

Despite the focus on health care, interest in health per se has resurfaced in policy debates. The beginnings of this resurgence are clear in the RAND Health Insurance Experiment²⁴ in which social scientists studied, among other things, the consequences of health financing arrangements on people's health. This experiment fostered a movement toward conceptualizing and measuring health for medical outcomes assessment. Its goal has been assessing the effects of medical care on health, especially health-related quality of life.²⁵ These efforts have reclaimed a concern for health in health care, but this movement has worked primarily at a *practical level*, leaving philosophical questions about health unaddressed.

This Article offers a philosophical justification for a right to health.²⁶ As such it makes a case for the right to health as a meaningful and operational right and discusses the degree to which this right is necessarily "justiciable" and enforceable as prescribed in international law. The theoretical framework I propose in this Article builds on and integrates Aristotle's political theory, the capability approach,²⁷ and a social choice paradigm known as incompletely theorized agreements. I draw on these perspectives to develop a theory of a right to health and to explicate societal obligations, both state and non-state, for progressive realization of this right. Finally, this Article argues that sustaining the effort to realize a

Occasional Paper No. 19, 1972).

24. JOSEPH P. NEWHOUSE, *FREE FOR ALL? LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT* (1993).

25. See ROBERT H. BROOK ET AL., *THE EFFECT OF COINSURANCE ON THE CONCEPTUALIZATION AND MEASUREMENT OF HEALTH FOR ADULTS IN THE HEALTH INSURANCE STUDY: OVERVIEW* (1979); ALLYSON R. DAVIES & JOHN E. WARE JR., *MEASURING HEALTH PERCEPTIONS IN THE HEALTH INSURANCE EXPERIMENT* (1981); *MEASURING FUNCTIONING AND WELL-BEING: THE MEDICAL OUTCOMES STUDY APPROACH* (Anita L. Stewart & John E. Ware eds., 1992); DONALD L. PATRICK & PENNIFER ERICKSON, *HEALTH STATUS AND HEALTH POLICY: ALLOCATING RESOURCES TO HEALTH CARE* (1993); Marilyn C. Bergner et al., *The Sickness Impact Profile: Conceptual Formulation and Methodological Development of a Health Status Index*, 6 INT'L J. HEALTH SERVS. 395 (1976); James W. Bush, *General Health Policy Model/Quality of Well-Being (QWB) Scale*, in *ASSESSMENT OF QUALITY OF LIFE IN CLINICAL TRIALS OF CARDIOVASCULAR THERAPIES* (Nanette K. Wenger et al. eds., 1984); Robert M. Kaplan & John P. Anderson, *A General Health Policy Model: Update and Applications*, 23 HEALTH SERVS. RES. 203 (1988); Ralf M. Rosser & Peter Kind, *A Scale of Valuations of State of Illness: Is There a Social Consensus?*, 7 INT'L J. EPIDEMIOLOGY 347 (1978); Anita L. Stewart et al., *The MOS Short-Form General Health Survey: Reliability and Validity in a Patient Population*, 26 MED. CARE 724 (1988); Alvin R. Tarlov et al., *The Medical Outcomes Study: An Application of Methods for Monitoring the Results of Medical Care*, 262 J. AM. MED. ASS'N 925 (1989).

26. For an excellent discussion of capabilities and human rights more generally, see Martha Nussbaum, *Capabilities and Human Rights*, 66 FORDHAM L. REV. 273 (1997); and Amartya Sen, *Elements of a Theory of Human Rights*, 32 PHIL. & PUB. AFF. 315 (2004), though neither discusses the right to health in their work.

27. Both Martha Nussbaum and Amartya Sen have worked on different versions of the capability approach. For the purposes of this Article, I draw on both, but build to a greater extent on Sen's version.

right to health requires individual and societal commitments to what I call *public moral norms*. In other words, in this Article I argue for treating the right to health as an *ethical demand for equity in health*. This ethical demand will likely involve legal instruments for enforcement, but more likely will require individuals, states, and non-state actors to internalize *public ethical norms* to enhance implementation and compliance with a right to health in international human rights policy and law.

This work, therefore, has something in common with studies in international law compliance that focus on what Harold Koh has called “transnational legal processes” for internalizing norms.²⁸ What is different, however, is this Article’s focus on an ethical paradigm that emphasizes a particular type of norm—a *public moral norm*—as the basis of individual and societal commitment to a right to health, and its focus on internalizing this public moral norm at *both* the collective (as through groups and institutions) and individual levels. The regulation of self and society, I argue, requires *not just legal instruments*, but individuals and groups with internalized public moral norms—as part of their own internal value systems—that inform the choices *they make for themselves and their society* to ensure capabilities to be healthy for all people. Such internalization in turn leads to the greater efficacy of, and greater compliance with, *domestic* policy and legal instruments, which I argue are as—if *not more*—important than international instruments (and institutions) for progressive realization of a right to health. Such realization is more likely to occur, I argue, when individuals within a given society take ownership of the public moral norm as a guiding principle for their individual and collective efforts, as evidenced by their *domestic* social, political, and economic activity.²⁹

This Article proceeds in four stages. Part I reviews the literature in medical ethics, demonstrating how the field has largely neglected the right to health as an object of ethical analysis and identifying key questions to be addressed in justifying the idea of the right to health through ethical inquiry. Part II grounds the right to health in Aristotle’s political theory and Amartya Sen’s capability approach. Drawing on moral and political

28. Harold Hongju Koh, *How Is International Human Rights Law Enforced?*, 74 IND. L.J. 1397 (1999); Harold Hongju Koh, *Transnational Legal Process*, 75 NEB. L. REV. 181 (1996).

For more on transnational legal process, see ABRAM CHAYES ET AL., INTERNATIONAL LEGAL PROCESS: MATERIALS FOR AN INTRODUCTORY COURSE (1968); LOUIS HENKIN, HOW NATIONS BEHAVE 47 (2d ed. 1979); MARGARET KECK & KATHRYN SIKKINK, ACTIVISTS BEYOND BORDERS: ADVOCACY NETWORKS IN INTERNATIONAL POLITICS (1998); Abram Chayes & Antonia Handler Chayes, *On Compliance*, 47 INT’L ORG. 175, 195 n.64 (1993); Martha Finnemore & Kathryn Sikkink, *International Norm Dynamics and Political Change*, 52 INT’L ORG. 887 (1998).

29. Elsewhere, I argue for widespread internalization of the public moral norm of willingness to pay taxes for others’ health insurance to achieve domestic health care reform on universal health insurance in the United States. See Jennifer Prah Ruger, *Health, Health Care and Incompletely Theorized Agreements: A Normative Theory of Health Policy Decision-Making*, 32 J. HEALTH POLITICS, POLICY & LAW (forthcoming 2007).

philosophy, I argue that the Aristotelian-capability view (which I will refer to as the “capability” view, for simplicity) provides the basis for the special moral importance of what I call health capabilities as the central focal variable for assessing equality and efficiency in health policy. These lines of thought take a universal view of humans’ capability to flourish as an end of political activity and provide an analytical framework to address questions of justice and human rights in a way that other philosophical schools do not.

Part III draws on social choice theory and in it I advance incompletely theorized agreements (ITA) as an approach to collective decision-making in public policy and human rights. Here I build on previous work in legal decision-making by extending ITA in at least three respects: moving beyond judicial decision-making to human rights and public policy; specifying the framework to health and health care decision-making; and combining ITA with the capability approach to advance the operationalization of the capability view. I argue that the ITA framework helps extend the capability approach when “dominance partial ordering” and incomplete specification fail to provide reasonable procedures for resolving conflict among different views. I suggest that the capability approach needs such a framework for social choice. ITA thus picks up where the capability approach leaves off, providing a framework for resolving conflict among divergent views. More specifically, health and health capabilities are multidimensional concepts about which different people have different and sometimes conflicting views. No unique view of health exists as the ideal for all evaluations of a right to health. The incomplete ordering of the capability approach, in combination with the incompletely theorized agreement on that ordering, I argue, allows for reasoned public policy development and analysis in the face of plural goods and different, even conflicting, views.

Part IV aims to provide a workable operationalization of a right to health. It establishes the scope and content of a right to health and identifies which dimensions of health may require prioritization when resources are scarce (a condition attached to the right to health in international law). This section seeks an agreed-upon or shared standard of health because, I argue, the demands of social justice and the right to health according to the capability view require a universally shared norm of health to establish a framework for interpersonal health comparisons. On the capability view, the challenge is to construct a conception of health that satisfies the trans-positional requirement to reflect the “view from everywhere.”³⁰

Finally, applying an ethical framework to the right to health necessitates

30. Amartya K. Sen, *Positional Objectivity*, 22 PHIL. & PUB. AFF. 126 (1993).

understanding the corresponding duties and obligations of individuals, states, and non-state actors. It also provides a framework for *state* health reform efforts, based on the belief that the underlying goal of health policy is the fulfillment of the right to health. Such efforts would place health and human flourishing at the center of health policy, law, and practice in all states.

I. ESCHEWING A RIGHT TO HEALTH: APPROACHES TO MEDICAL ETHICS AND A RIGHT TO HEALTH CARE³¹

Medical ethics is the focus of a vast literature on justice and medical care, and there are numerous accounts of what justice requires in terms of the distribution of *medical care* services. Existing approaches to medical ethics have not typically addressed universal concerns of social justice with respect to *health*; instead, such theories have shied away from health as an objective.³² As this section illustrates, in general, existing theories assume that human health is not a *suitable or appropriate* focal variable for assessing social justice and rights.

A. Utilitarianism and Health Policy

Utilitarianism is one of the dominant analytical models of health economics and has gained a considerable presence in health policy as a standard framework for health policy analysis. The utilitarian approach is expected to become even more widespread in health policy analysis, given its endorsement in a report delivered by the Panel on Cost-Effectiveness in Health and Medicine,³³ which the United States Public Health Service created in 1993 to delineate standardized cost-effectiveness guidelines for use in health and medicine. The panel made many recommendations, one of which was a preference-based system of health policy analysis which captures people's preferences for different states of health as the focus of analysis. The panel recommended Quality-Adjusted-Life-Years (QALYs)—a health utility index—for the reference case.

Utilitarian theories of health care justice require allocations and thus social arrangements (and sometimes instrumental rights)³⁴ that maximize

31. See Jennifer Prah Ruger, *Health, Capability, and Justice: Toward a New Paradigm of Health Ethics, Policy and Law*, 15 CORNELL J.L. & PUB. POL'Y (forthcoming 2006), for a more comprehensive review and analysis; this section summarizes only a few major theories in medical and public health ethics.

32. Similar issues arise in the ethics of public health. See, e.g., Nancy E. Kass, *An Ethics Framework for Public Health*, 91 AM. J. PUB. HEALTH 1776 (2001).

33. See COST-EFFECTIVENESS IN HEALTH AND MEDICINE (Marthe R. Gold et al. eds., 1996).

34. To the extent that utilitarians acknowledge rights at all, they do so instrumentally—rights have no moral basis other than that their protection over time maximizes net social utility. Rights here have an unsubstantiated foundation in that they are contingent upon overall utility maximization. On the application of utilitarianism to health policy and the issue of instrumental rights, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* (1994).

net social utility. Under utilitarianism, a right to health care would be justified if it contributed to the overall maximum of net social utility. It would also be changeable if utility changed. The types of health care services allocated would be those that maximized net social utility. Utilitarianism takes the principle of utility as absolute and does not necessarily give health a special place in that theory.

In addition, utilitarianism accounts for *aggregate* welfare without taking note of the distributional concerns over benefits and burdens in society. There are no moral limits on measures to increase utility; utilitarianism tolerates large inequalities to increase total or average net social utility. Utilitarianism also omits freedom as a good in itself and concentrates on achievements alone; it ignores values not reflected in measured utility. It is particularly limited in the presence of entrenched inequalities—situations of persistent deprivation and adversity due to “adaptive preferences,” or a person’s adjustments to his circumstances—which develop when a person’s reduced functioning makes him appear to be not so badly off in terms of utility.³⁵ The root problem is that desires and subjective preferences (which pertain to utility) are easily malleable. And it is not clear that individuals really know or fully understand what makes them happy in such situations. A deprived person might not have enough information or adequate education about the world to make reliable statements about her happiness. Commensurate measures of utility do not give us a good picture of relative well-being in functional terms. This makes interpersonal comparisons of utility difficult in health policy. In contrast, as Part II will show, the capability approach takes account of deprived persons’ inability to achieve even elementary functionings.

B. Communitarian Theories

Communitarian theories of justice, as put forth by Michael Sandel and others,³⁶ offer a relativist account of justice and health care and public health whereby the provision of health care is justified by the shared expression of values in a given community.³⁷ According to communitarian theorists such as Michael Walzer, there is no single principle of justice that governs the distribution of all social goods. Instead, under this theory, societies construct principles internally by societies of humans as they evolve politically and constitute distinct “spheres of justice.”

35. See AMARTYA K. SEN, *ON ETHICS AND ECONOMICS* (1987); AMARTYA K. SEN, *THE STANDARD OF LIVING* (1987).

36. LIBERALISM AND ITS CRITICS (Michael J. Sandel ed., 1984); ALASDAIR MACINTYRE, *WHOSE JUSTICE? WHICH RATIONALITY?* (1988); MICHAEL J. SANDEL, *LIBERALISM AND THE LIMITS OF JUSTICE* (1982); Michael Walzer, *The Communitarian Critique of Liberalism*, 18 *POL. THEORY* 6 (1990).

37. Hence, the justification for health care and public health under this theory varies by community.

Communitarians take community norms or values as their absolute principles, and health might or might not be included as a special good, depending upon the community's shared values. Ezekiel Emanuel has also proposed an approach that is primarily communitarian but includes aspects of libertarianism. According to Emanuel, an ideal system would be to allow deliberative democratic communities to develop shared conceptions of the good life and justice.³⁸ Communitarian theories applied to the United States, for instance, might find that the American free-market tradition supersedes the principle of equal access to health care.

C. The Libertarian Perspective

Libertarian theories of justice, as advocated by Robert Nozick³⁹ and others, would deny altogether any societal obligation to provide medical care or health insurance or other health determinants to all because the increased taxes required would infringe on individual liberties. Libertarianism takes the principle of liberty as absolute and does not give health special standing.

The "liberal consensus" in human rights scholarship and practice generally takes a libertarian approach, endorsing the fulfillment of "negative rights" (civil and political rights) but failing to endorse the fulfillment of "positive rights."⁴⁰ The liberal consensus on universal human rights rejects altogether social, economic, and cultural rights, arguing that taxing the wealthy to fulfill the positive rights of those who cannot afford to provide for themselves diminishes wealthier individuals' civil liberties or negative rights. Thus, a libertarian perspective supports national laws that guarantee negative freedoms, but in general opposes the redistribution of resources required to fulfill positive rights.

D. Rawls's Theory of Justice

In John Rawls's liberal view, rational agents standing behind a veil of ignorance about their personal circumstances would choose principles of justice that maximize the minimum level of primary goods: goods that are rational to want, regardless of whatever else one wants. Primary goods are allocated to individuals on the basis of fair equality of opportunity due to the disadvantages that have accrued to these individuals through the natural lottery, the distribution of advantageous and disadvantageous attributes by birth, and the social lottery, the distribution of social assets or deficits through family property, school systems, and so on.⁴¹ A major

38. See EZEKIEL J. EMANUEL, *THE ENDS OF HUMAN LIFE: MEDICAL ETHICS IN A LIBERAL POLITY* (1991).

39. See generally ROBERT NOZICK, *ANARCHY, STATE, AND UTOPIA* (1974).

40. Tony Evans, *A Human Right to Health?*, 23 *THIRD WORLD Q.* 197, 199-203 (2002).

41. JOHN RAWLS, *A THEORY OF JUSTICE* 12, 15, 90-95 (1971).

concern with the Rawlsian approach, despite its many advantages, is that it focuses on means rather than ends and does not account for human diversity.

As will become clear in what follows, the Rawlsian account falls short because it does not consider that “human beings have variable needs for resources, and any adequate definition of the better off and worse off must reflect that fact,” as Martha Nussbaum argues.⁴² For instance, two persons holding the same bundle of primary goods, as Sen puts it, “can have very different freedoms to pursue their respective conceptions of the good.”⁴³ This critique is especially poignant in assessing the effects of health care and of other resources on health. It is necessary, then, to assess the impact of these resources on health, in order to understand their instrumental effectiveness and to allocate them in an equitable and efficient manner. Rawls’s theory, as Nussbaum notes, “by defining being well-off in terms of possessions alone, fails to go deep enough in imagining the impediments to functioning that are actually present in many human lives.”⁴⁴

Rawls, moreover, expressly avoided focusing on health in his theory because, he suggested, no society can guarantee health to its individuals.⁴⁵ Although Rawls later changed his position slightly in *The Law of Peoples* by including health care as one of the primary goods,⁴⁶ his main contention in *A Theory of Justice* is that natural goods like health are not on the list of primary goods—goods that are rational to want. Regarding natural goods, Rawls states in *A Theory of Justice* that “other primary goods such as health and vigor, intelligence and imagination, are natural goods; although their possession is influenced by the basic structure [of the society], they are not so directly under its control.”⁴⁷

E. Fair Equality of Opportunity

The egalitarian rights-based theory put forward by Norman Daniels⁴⁸ and his colleagues—and building on Rawlsian theory—argues for a right to health care on the basis of “equality of opportunity.” It proposes that

Social institutions affecting health care distribution should be arranged, as far as possible, to allow each person to achieve a fair share of the normal range of opportunities present in that society. The normal range of opportunity is determined by the range of life plans

42. Martha C. Nussbaum, *Human Functioning and Social Justice: In Defense of Aristotelian Essentialism*, 20 *POL. THEORY* 202, 233 (1992).

43. AMARTYA K. SEN, *INEQUALITY REEXAMINED* 8 (1992).

44. Nussbaum, *supra* note 42, at 233.

45. See RAWLS, *supra* note 41, at 62.

46. JOHN RAWLS, *THE LAW OF PEOPLES* 50 (1999).

47. RAWLS, *supra* note 41, at 62.

48. See DANIELS, *supra* note 9.

that a person could reasonably hope to pursue, given his or her talents or skills.⁴⁹

Under this theory, the social obligation to provide health care is different from and prior to the social obligation to provide other primary goods. Although Daniels claims priority for health care and insulates it from other social goods, his theory does not discriminate among the different types of health care that society is obliged to provide its citizens under an “equality of opportunity” approach. It is easy to see how this approach can be problematic given the widespread and seemingly limitless array of factors that limit opportunity.

In later works Daniels and colleagues apply Rawls’s theory to setting limits in health care⁵⁰ and to the social determinants of health,⁵¹ arguing that justice requires “flattening socioeconomic inequalities in a robust way, assuring far more than a decent minimum,”⁵² and arguing that, essentially, “health is the by-product of justice.” Sen and others have criticized this view, stating that it “oversimplifies the demands of health equity vis-à-vis the extensive requirements of justice.”⁵³ This critique sheds light on the distinction between a “resource-orientation” (Rawlsian) and a “results-orientation” (capability) in public policy.

Moreover, Daniels, like Rawls, expressly avoided universal concerns of social justice with respect specifically to health. Because “a right claim to equal *health* is best construed as a demand for equality of access or entitlement to health *services*,”⁵⁴ the notion of a “right to health” embodies a confusion about the kind of thing which can be the object of a right claim.⁵⁵ By giving moral weight only to the resources that may create health, Daniels’s theory does not see health and human flourishing as an end itself.

While a focus on fair distribution of primary goods and equal opportunity elevates the importance of the social determinants of health, this view has limitations, especially in acknowledging the intrinsic value of health and other capabilities, in analyzing the relative effectiveness of resources on health and health inequalities, and in understanding public policy more broadly.⁵⁶ It concentrates on the “inputs” for health, while

49. See BEAUCHAMP & CHILDRESS, *supra* note 34, at 340.

50. NORMAN DANIELS & JAMES E. SABIN, *SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES* (2000).

51. Norman Daniels, *Justice, Health, and Health Care*, in *MEDICINE AND SOCIAL JUSTICE: ESSAYS ON THE DISTRIBUTION OF HEALTH CARE* 6 (2002) [hereinafter Daniels, *Health and Health Care*]; NORMAN DANIELS ET AL., *IS INEQUALITY BAD FOR OUR HEALTH?* (2000) [hereinafter DANIELS ET AL., *BAD FOR OUR HEALTH*].

52. Daniels, *Health and Health Care*, *supra* note 51, at 13.

53. Amartya Sen, *Foreword* to DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at vii.

54. DANIELS, *supra* note 9, at 7.

55. *Id.* at 6.

56. Jennifer Prah Ruger, *Ethics of the Social Determinants of Health*, 364 *LANCET* 1092, 1093

paying little heed to the “output”—whether or not health or health capability is actually achieved. As two well-known medical ethicists have put it, egalitarian theories “propose that persons be provided an equal share of certain goods such as health care, but all prominent egalitarian theories of justice are cautiously formulated to avoid making equal sharing of all possible social benefits a requirement of justice.”⁵⁷

In contrast, according to the theoretical framework presented here, increasing the supply or access to health care, important as that is, would *not necessarily* achieve justice. Rather, as I note in Part II, this approach would focus on reducing inequalities in individuals’ capabilities to achieve good health. Such an approach involves drawing on social and economic analysis, to understand and assess the determinants and consequences of disparities in abilities to achieve good health.

Economic analysis is important to assess the instrumental effectiveness and the cost-effectiveness of the determinants of health capability. From a capability perspective it is insufficient to assume that premature death and avoidable morbidity will necessarily be averted through more and more technologically advanced health care. While health care certainly has an impact on mortality and morbidity,⁵⁸ its impact often depends on the type of medical care and is often secondary to or contingent upon the impact of other factors.

For instance, high-technology neonatal intensive care can do much to reduce infant mortality, especially in the United States where this medical technology is of high quality and is often readily available. However, the route through which a fetus and subsequently the newborn becomes at risk for prematurity or perinatal death is often primarily through the impact of the internal and external characteristics of the birth mother—e.g., high stress, poverty, low educational level, lack of prenatal education and information, poor nutrition and sanitation, smoking, alcohol and drug abuse, exposure to pollutants and other external toxins, a lack of basic prenatal and birthing services, a high disease burden or other co-morbid conditions occurring during pregnancy and complications from reproductive technologies.

The case of HIV/AIDS among women provides another example. Women are disproportionately affected by AIDS in developing countries; sixty percent of individuals living with HIV/AIDS in sub-Saharan Africa are women. Many women would want to avoid contracting HIV through safe sex practices, but their capability to do so is significantly restricted by their disempowerment and their inferior status relative to men in many

(2004).

57. BEAUCHAMP & CHILDRESS, *supra* note 34, at 233.

58. See, e.g., DAVID CUTLER, *YOUR MONEY OR YOUR LIFE: STRONG MEDICINE FOR AMERICA’S HEALTH CARE SYSTEM* (2004) (arguing that spending on medical care is worth the cost).

social contexts.⁵⁹ AIDS prevention and treatment requires empowering individuals to act and bring about change in their own terms and improving the economic, cultural, political, and social conditions for women to choose safer life strategies and conditions. Such conditions can be created through changes in social norms and economic, political, and civil opportunities that empower women within the family and in their relationships with men.

Different people will convert the same access to health care into different health achievements and freedoms. Consider an example of two individuals, both of whom have health insurance. If one person lives in an unheated home while the other lives in a heated home, the ability of these two people to convert medical care services into good health in the winter will be different due to their different external circumstances. Similarly, lack of air conditioning in the summer can cause illness, even death, for some. Consider another example involving two women—a single mother working a job with long hours to make ends meet and a stay-at-home married woman with a nanny to help with child care. In the case with the single mother, it may be difficult, if not impossible, to get her child to the doctor, given her demanding schedule—she simply may not be capable of taking time off of work to travel to and from the doctor's office and to wait for treatment for her child. In this case, the woman's external circumstances make up significant barriers to receiving the health care to which she may very well be entitled. Contrast her situation with the other woman who can afford the time and expense of either herself or her nanny taking her child to the doctor at any time necessary. This is not to deny that equal health insurance coverage is not a good idea and that health care has an effect on health. Rather, these examples underscore the importance of assessing the consequences of those resources in terms of health and health capability.

There is considerable research to be done on the relative impact and cost-effectiveness of health determinants and the impact of interactions between health care services and other resources and policies.⁶⁰ This Article will demonstrate some of the ways in which the capability view avoids the omissions and oversights of other frameworks.

In this Article, I offer an account of capability and health that takes health as a focal object of justice and efficiency in health policy and human rights. It follows from this account that health capabilities should be the central focal variable for assessing the equity and efficiency of

59. Jennifer Prah Ruger, *Combating HIV/AIDS in Developing Countries*, 329 BRIT. MED. J. 121, 121 (2004).

60. The same can be said at the global level of the impact of international policies on global health inequalities. On this see Jennifer Prah Ruger, *Fatal Indifference: The G8, Africa and Global Health*, 95 J. PUB. HEALTH POL'Y 60 (2005).

health policy and law. More specifically, universal attention to people's capability to avert premature mortality and address avoidable morbidity should be the morally central or prior objective of health policy and law. We have a special social obligation to develop these capabilities above and beyond our obligation to ensure non-central health capabilities. This Article stresses that this social obligation is universal—applying to all human lives, irrespective of class, gender, race, ethnicity, sexual orientation, or community. The focus on central health capabilities—the capability to avoid premature mortality and address escapable morbidity—as morally privileged stems from the need to ensure certain *critically important functionings up to certain minimally adequate levels*. As Sen notes, there is a “particular moral and political importance” that is associated with fulfilling these well-recognized and urgent claims.⁶¹

It follows that, according to the capability view, whether a group or person is “worse-off” or “well-off” cannot be determined by access to health care or other primary goods. This information does not “go deep enough in imagining the impediments to functioning that are actually present in many human lives,” as Nussbaum puts it.⁶² Instead, under this account, analyzing individuals' ability to achieve good health can aid, and should be employed, in the evaluation of health policies and laws. This information can be particularly useful: (i) in shedding light on existing *inequalities* and *deprivations* in people's capability to achieve good health; and (ii) to identify the policies that can ameliorate inequalities and deprivations effectively and efficiently.

Existing theories of medical and social ethics and traditional approaches to health policy and law leave these questions unaddressed. The capability view can help answer them, because it sees people's capability to flourish as an end of political activity and provides an analytical framework to address questions of justice and efficiency in public policy in a way that other approaches do not.

II. GROUNDING THE RIGHT TO HEALTH AND HUMAN FLOURISHING

A. Aristotle

The Aristotelian view is comprised of several major components.⁶³ The

61. SEN, *supra* note 43.

62. Nussbaum, *supra* note 42, at 233.

63. This Article relies on the following translations and discussions of Aristotle's *The Politics* and *Nicomachean Ethics*: ARISTOTLE, *NICOMACHEAN ETHICS* (Terence Irwin trans., Hackett Publ'g Co. 2d ed. 1999) [hereinafter ARISTOTLE, *NICOMACHEAN ETHICS*]; ARISTOTLE, *THE POLITICS* (Cames Lord trans., Univ. of Chi. 1984) [hereinafter ARISTOTLE, *POLITICS*]; Martha C. Nussbaum, *The Good as Discipline, the Good as Freedom, in THE ETHICS OF CONSUMPTION: THE GOOD LIFE AND GLOBAL STEWARDSHIP* 312 (David Crocker & Toby Linden eds., 1998) [hereinafter Nussbaum, *Good as Discipline*]; Nussbaum, *supra* note 42; and Martha C. Nussbaum, *Nature, Function, and Capability*:

first is that human flourishing⁶⁴ is the end of all political activity. This is Aristotle's theory of the good, the supreme good, the good that is the aim of "every action and decision."⁶⁵ As Aristotle notes, "It belongs to the excellent legislator to see how a city, a family of human beings . . . will share in the good life and in the happiness that is possible for them."⁶⁶ This conception also expresses the idea of "capability"—what humans are able to do and be and what "is possible for them," and it suggests that our social obligation involves enabling all to live flourishing lives.

The political goal, then, is defined, as Nussbaum puts it, in terms of "the capability to function well if one so chooses."⁶⁷ This formulation is important for justifying capability's central role in political activity.⁶⁸ It also distinguishes between achievement and the freedom to achieve. By focusing on the capability to achieve valuable functionings, the theory (1) secures differential allotments of goods and circumstances needed to produce capabilities; and (2) respects the central importance of freedom and reason in enabling humans to make choices.⁶⁹

Aristotle on Political Distribution, in ARISTOTELES' POLITIK 152 (Günther Patzig ed., 1990) [hereinafter Nussbaum, *Political Distribution*].

Invoking an Aristotelian point of view as a basis for social justice involves the application of this framework in a more universal way than was the case more than two thousand years ago. On this see Nussbaum, *Political Distribution*, *supra*. Indeed, since Sen's capability approach is both rooted in, yet departs from, Aristotle's work, it provides a good example of the various ways in which Aristotle's writings can be invoked for modern scholastic purposes. Furthermore, Aristotle's humanitarian focus—that human flourishing is the end of all social activity—has great appeal to scholarship focused on health.

I only discuss several relevant components of the Aristotelian view herein. For a more exhaustive exposition, see the voluminous work of Martha Nussbaum on the subject.

64. There has been some question about this translation of Aristotle's work in addition to concern over the internal inconsistency in Aristotle's writings that would lead one to question whether he actually held this view. For the purposes of this Article, I assume that Aristotle did hold this view and I accept the translation and discussion presented in Nussbaum, *Political Distribution*, *supra* note 63, to this effect.

65. ARISTOTLE, NICOMACHEAN ETHICS, *supra* note 63, at 1: 1094a1.

66. *Id.* at 201: 1325a7-10.

67. Nussbaum, *Political Distribution*, *supra* note 63, at 165.

68. Nussbaum's view on this is that there are three types of capabilities on which politics should be focused: (1) basic capabilities; (2) internal capabilities; and (3) combined capabilities. According to Nussbaum, basic capabilities are innate capabilities that are the necessary basis for developing more advanced capability. Basic capabilities include practical reason and imagination. Internal capabilities are those capabilities which are within a person and are sufficient conditions for the exercise of the requisite functions. An example of this type of capability is the case of sexual expression. A person who has not suffered genital mutilation, for instance, has the capability for sexual pleasure. Combined capabilities are internal capabilities combined with suitable external characteristics for functioning. An example of a combined capability, according to Nussbaum, is one in which a woman who is not genitally mutilated is prevented from sexual expression because she is secluded and forbidden to leave the house. In this case, the woman has internal but not external capabilities for sexual expression. On the question of justice and capabilities, Nussbaum responds that the "aim of public policy is the production of external capabilities—this means promoting the states of the person by providing the necessary education and care; and it also means preparing the environment so that it is favorable for the exercise of practical reason and other major functions." Nussbaum, *Good as Discipline*, *supra* note 63, at 16.

69. On this, Nussbaum, for example, makes the point that while functioning should be "held in view" by government—that we should use functionings as indicators of how people are doing—that

This component of Aristotelian theory is especially important for health policy and law. It requires the government to distribute sufficient goods, services, and conditions to achieve human functioning, while respecting human dignity by giving individuals the freedom to choose the life they want to lead.⁷⁰ For example, the state would need to provide the resources and circumstances for good nourishment while respecting the right to fast for religious purposes.⁷¹ This distinction is important for understanding both the state's role in distributive justice and the difference between the malnourished and those who are intentionally fasting. In short, this first component of Aristotle's theory is important for securing different allocations to people who need varying levels of resources to lead a flourishing life.

A second major component of the Aristotelian view is that resources, such as wealth, medical care, and income, do not constitute appropriate ends of political activity. As Aristotle argues, "[C]learly wealth is not the good we are seeking, since it is [merely] useful, [choiceworthy only] for some other end."⁷²

Instead, resources are merely a *means* to an end, each having instrumental, rather than intrinsic, value. Nussbaum also notes that resources "are not good in their own right; they are good only insofar as they promote human functioning."⁷³ This formulation is important because individuals' ability to function, rather than resources, should be the primary goal of public policy.

A third major component of the Aristotelian view concerns the evaluation of political arrangements—namely, that political arrangements aim at enabling people to function best, and "it is evident that the best . . .

capability is the political goal. This point rests on the importance that is placed on respecting humans' abilities for practical reason and choice—once capabilities are assured people must be free to make the choices they like. See Martha C. Nussbaum, *Non-Relative Virtues: An Aristotelian Approach*, in *THE QUALITY OF LIFE* 265 (Martha C. Nussbaum & Amartya K. Sen eds., 1993); Nussbaum, *Political Distribution*, *supra* note 63.

70. Other approaches to medical ethics have also emphasized a major role for choice; see, for example, H. TRISTRAM ENGELHARDT, *THE FOUNDATIONS OF BIOETHICS* (1st ed. 1986); CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* (1995); PAUL T. MENZEL, *STRONG MEDICINE: THE ETHICAL RATIONING OF HEALTH CARE* (1990); Loren E. Lomasky, *Medical Progress and National Health Care*, 10 *PHIL. & PUB. AFF.* 65 (1981); and Arti K. Rai, *Rationing Through Choice: A New Approach to Cost-Effectiveness Analysis in Health Care*, 72 *IND. L.J.* 1015 (1997), among others. Choice has been emphasized primarily because it embodies a respect for individual autonomy—and this centrality is present in all approaches that emphasize it, including the capability approach. Individual choice must be assessed, however, in the context of aggregative well-being—and the challenge of how to compare and weigh small benefits for many with large benefits for a few. The account of capability and health offered here is unique in the manner in which it integrates, rather than dichotomizes, individual autonomy and aggregative well-being—in this sense, the account brings together both deontological and consequentialist views. The account also considers the impact of external and internal characteristics on individual choice.

71. This example comes from SEN, *supra* note 43; see also Nussbaum, *Good as Discipline*, *supra* note 63.

72. ARISTOTLE, *NICOMACHEAN ETHICS*, *supra* note 63, at 5: 1096a6-8.

73. Nussbaum, *supra* note 42, at 233.

is that arrangement according to which anyone whatsoever might do best and live a flourishing life,"⁷⁴ given their natural circumstances. Individuals will inevitably face natural and social barriers that can impede optimal functioning. This acknowledges the difficulty of equalizing achievements—and notes that human diversity must be considered in the conception of political distribution. Aristotle's conception judges a political arrangement as best "provided that it secured to the people involved a good life up to the maximum permitted by circumstances."⁷⁵ Aristotle regards an arrangement as best if it "brings the people as close to good functioning as their natural circumstances permit."⁷⁶ When these formulations are combined, Aristotle's conception of political distribution implies, as Nussbaum notes, the view that the

aim of political planning is the distribution to the city's individual people of the conditions in which a good human life can be chosen and lived. This task aims at producing capabilities. That is, it aims not simply at the allotment of commodities, but at making people able to function in certain human ways. . . . The task of the city is, then, to effect the transition from one level of capability to another.⁷⁷

Although Aristotle's theory of political distribution rests on his theory of the human good "as what everything seeks,"⁷⁸ a fourth major element is that it also acknowledges the existence of other ends for various actions: "Since there are many actions, crafts, and sciences, the ends turn out to be many as well; for health is the end of medicine"⁷⁹ This passage is particularly instructive for justifying health as a primary objective of health policy. Thus, health has both intrinsic and instrumental value.⁸⁰

A fifth major claim of the Aristotelian view is Aristotle's emphasis on the need to define "human flourishing" in order to determine whether political arrangements promote it. Aristotle argues that "[c]oncerning the best regime, one who is going to undertake the investigation appropriate to it must necessarily discuss first what the most choiceworthy way of life is. As long as this is unclear the best regime must necessarily be unclear as well"⁸¹ This formulation calls for a "substantial account of the human good and what it is to function humanly"⁸² to assess a society's success or failure in meeting the goal of functioning and well-being. It places the Aristotelian view into the realm of theories that emphasize an "appeal to

74. See ARISTOTLE, *POLITICS*, *supra* note 63, at 199: 1324a23-25.

75. Nussbaum, *Political Distribution*, *supra* note 63, at 155.

76. *Id.*

77. *Id.* at 152.

78. ARISTOTLE, *NICOMACHEAN ETHICS*, *supra* note 63, at 1: 1094a3

79. *Id.* at 1: 1094a7-8.

80. Ruger, *Health and Development*, *supra* note 8, at 678.

81. ARISTOTLE, *POLITICS*, *supra* note 63, at 197: 1323a14-17.

82. Nussbaum, *Political Distribution*, *supra* note 63, at 152.

conceptions of the good life”⁸³ in justifying public policies and laws. Aristotle also argues that it is possible to specify functionings that constitute a good human life.⁸⁴

What has followed from this formulation of the Aristotelian view is an attempt to completely specify the list of functionings that constitute “human flourishing.” There has been some controversy over this attempt which typically concerns whether there exists a “true” view of human flourishing or whether human flourishing is culturally defined. On one end of the spectrum, cultural relativists argue that even such basic human experiences as reasoning and happiness are culturally or socially constructed. On the other end of the spectrum is the strict Aristotelian view that human flourishing is purely objective—that human flourishing entails certain objective elements. And positions exist in between these opposite ends of the spectrum. For the purposes here, this distinction is important, but as discussed in subsequent sections, the resolution of this issue is less important than the practical policy solution. This Article offers not a resolution to the definitional question of what human flourishing or health are, but a framework for establishing the important aspects of health regardless of theoretical details. In subsequent sections I suggest that such a framework calls for incomplete theorization on such matters about which there is a “fair amount of agreement”—to meaningfully evaluate health-related goods and services for policy purposes.

On an Aristotelian view, an account of the human good involves identifying a list of functionings at a certain level of generality, allowing more local and personal specificity for practical application. Under this view, the processes of specifying the list of functionings and assessing the most effective means of enabling people to achieve them should be a rational, empirical investigation, deliberative in nature. Deliberation, according to Aristotle, involves an investigation and analysis, “[f]or a deliberator would seem to inquire and analyze . . . as though analyzing a diagram.”⁸⁵ He also stresses that deliberating citizens might require help from experts, emphasizing the need for those with experience to take part in decision-making, since they are the best judges of what they know well. Reinforcing this idea, he argues: “Further, each person judges rightly what he knows, and is a good judge about that; hence the good judge in a given area is the person educated in that area . . .”⁸⁶ At the same time, Aristotle warns against exactitude and precision in decision-making, stating that “the educated person seeks exactness in each area to the extent that the

83. EMANUEL, *supra* note 38, at 8.

84. See Nussbaum, *Political Distribution*, *supra* note 63, at 154.

85. ARISTOTLE, *Nicomachean Ethics*, *supra* note 63, at 35: 1112b20-22.

86. *Id.* at 2-3: 1095a1-3.

nature of the subject allows.”⁸⁷

A key aspect of successful deliberation, Aristotle argues, is the virtue of practical wisdom or prudence which “must be a state grasping the truth, involving reason, and concerned with action about human goods.”⁸⁸ Through use of practical wisdom, deliberators will be able to judge wisely what is good and expedient for humans and what can effectively be brought about. Thus, practical wisdom must concern itself with particulars as well as with broader, universal concepts. Justice, like the other Aristotelian virtues, involves a balance between general ethical rules and particulars in which both are subject to assessment and revision. This formulation supports social decision-making as an ongoing, iterative process which incorporates new information as it becomes available. It also asserts government’s responsibility for developing individual capabilities for participation and deliberation. Applying these formulations to health, health policy, and law offers a framework for deliberations among citizens and experts that range from broader decision-making about laws and policies to discussions of specific medical treatments.⁸⁹

Aristotle also recognizes the difficulty of choosing among items that cannot readily be compared. Solving disagreements and making effective choices is a critical element of the Aristotelian view, and it has practical implications. Deliberation is concerned, by its very nature, with indeterminate things; “the right way to act is undefined.”⁹⁰ For if “we encounter an impossible step—for instance, we need money but cannot raise it—we desist; but if the action appears possible, we undertake it. What is possible is what we could achieve through our agency [including what our friends could achieve for us] . . .”⁹¹ Although Aristotle emphasizes the importance of making definitive decisions and taking actions as a result of deliberation, he provides less guidance on how to come to agreement on principles and particulars. As Part III will establish, an incompletely theorized agreements framework for resolving disagreements when making practical decisions can extend these ideas.

Finally, Aristotle provides guidance on distributing limited resources to promote flourishing lives through his principle of proportional justice. Aristotelian justice treats like cases alike and different cases differently. In Part IV below, I apply this principle of proportional justice to health and suggest it would require society to reduce barriers to equal capabilities for health, especially by giving significant weight to the needs of the worse-

87. *Id.* at 2: 1094b24-25.

88. *Id.* at 90: 1140b21-22.

89. For further discussion of reasoned consensus through scientific and deliberative processes for allocating health care resources, see Ruger, *supra* note 31, at Part IV.C.1-2.

90. ARISTOTLE, NICOMACHEAN ETHICS, *supra* note 63, at 35: 1112b10.

91. *Id.* at 36: 1112b25-28.

off as compared to those of the better-off, in proportion to their difference. Aristotle introduced the concept of “disproportionate” effort, which aims to bring disadvantaged individuals as close as possible to a threshold level of functioning that is possible for them.

Ultimately, Aristotle’s principle of proportional justice applied to health would support allocation of resources to those in greater need to bring them to as close to a certain level of functioning as their circumstances admit. Aristotle’s efforts to qualify this principle in accordance with the constraints some individuals face help to understand the limits on our social obligation to allocate resources. Aristotle emphasizes practical reasoning, arguing that one person’s agency cannot be sacrificed to improve another person’s functioning, even if the latter still falls short of normal functioning. For health care, these formulations would generally imply that the government should bring each individual’s health functioning as close to a threshold level of functioning that is possible for them—if the individual’s circumstances permit—without dropping that of others below the normal range. There is currently considerable discussion about how much priority society should give to its most needy, and efforts to craft a flexible compromise between strict maximization and prioritization are necessary.⁹²

*B. Sen’s Capability Approach*⁹³

Amartya Sen has formulated a capability approach that is closely connected to the Aristotelian conception of social and political ethics through his emphasis on capability as the focal variable for social evaluation. Like Aristotle, Sen asserts the importance of freedom, attaching value to choice and opportunities for individuals to live the life they choose given their personal and social circumstances.

The capability approach rests on several major claims. The first is that equality can be judged in numerous ways and that other approaches, while all egalitarian, differ by the focal variable used to assess equality. Income-egalitarians demand equal incomes, for instance; welfare-egalitarians require equal welfare levels; classical utilitarians demand equal weights for all utilities; and pure libertarians demand equality of rights and liberties. In critique, Sen asks: “Equality of what?”

Both Sen’s approach and the Aristotelian view hold that resources such as wealth, income, and health care are not appropriate standards for ethical evaluation. They make individual capability to achieve valuable functionings the focal variable for social evaluation. The capability

92. For further discussion of the so-called bottomless pit problem and the application of reasonable accommodation, see Ruger, *supra* note 31, at Part IV.C.9.

93. This section relies on SEN, *supra* note 43, and AMARTYA K. SEN, DEVELOPMENT AS FREEDOM (1999).

approach, like the Aristotelian view, focuses on the capability to lead a worthwhile life. It applies this freedom to all members of society, irrespective of race, class, gender, community, sexual orientation, or ethnicity. Capability to function, Sen argues, incorporates both well-being and the freedom to pursue well-being.

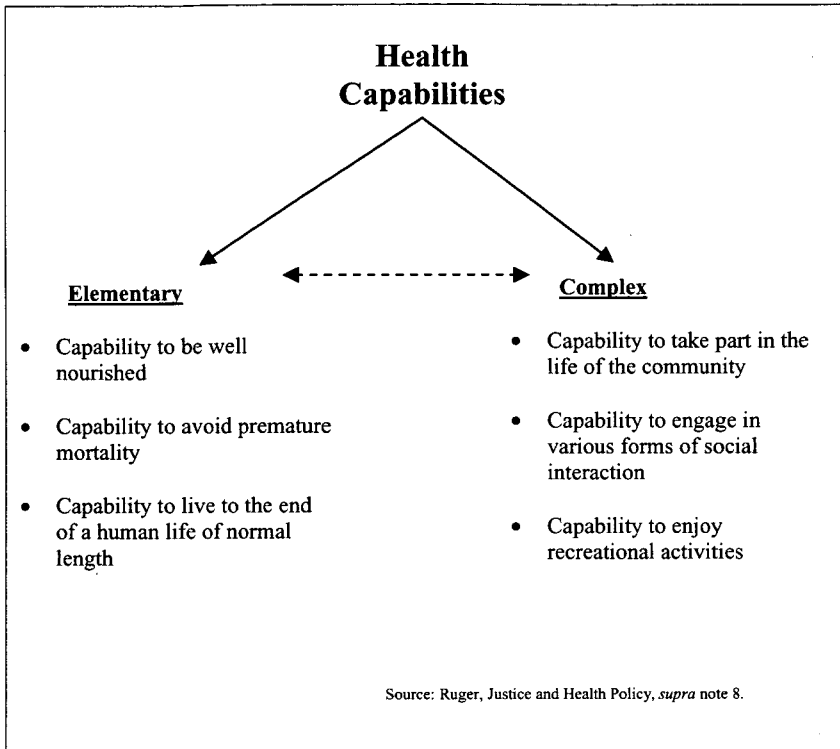
Capability relates to well-being in two ways. First, if a set of functions, such as the ability to feed oneself and walk unaided, constitute a person's well-being, then the capability to achieve those functions will constitute the person's freedom to have well-being. This is important if freedom is valued for itself, not just for instrumental purposes. Because the capability approach regards freedom as an intrinsic value, it defines a good society as one that aspires to freedom. Second, well-being depends on the capability to function. The opportunity to exercise freedom can itself be valuable, and thus real opportunities, Sen argues, would be better.⁹⁴

He notes that a set of capabilities provides information about the vectors of functioning within a person's reach. This information is important, regardless of how well-being is characterized. The "amount or the extent of each functioning enjoyed by a person may be represented by a real number, and when this is done, a person's actual achievement can be seen as a *functioning vector*."⁹⁵

94. SEN, *supra* note 43, at 7.

95. SEN, *supra* note 93, at 75.

Figure 1: Range of Health Capabilities



Capabilities and functions occupy the same categorical “space,” but a functioning combination or vector is a *point* in space whereas a capability is a *set* of such points. “Capability is a set of such functioning n tuples, representing the various alternative combinations of functionings from which the person can choose one”⁹⁶ The capability set is not directly observable, but it is similar to a budget that is constructed from empirical data. “A person’s ‘capability’ refers to the alternative combinations of functionings that are feasible for her to achieve. Capability is thus a kind of freedom: the substantive freedom to achieve alternative functioning combinations (or, less formally put, the freedom to achieve various lifestyles).”⁹⁷ Sen argues that the evaluative focus of the capability approach “can be either on the *realized* functionings (what a person is actually able to do) or on the *capability set* of alternatives she has (her real opportunities).”⁹⁸ In terms of social evaluation of public policies, Sen

96. SEN, *supra* note 43, at 50.

97. SEN, *supra* note 93, at 75.

98. *Id.*

argues that “individual functionings can lend themselves to easier interpersonal comparison than comparisons of utilities These are advantages of using the capability perspective for evaluation and assessment.”⁹⁹ On an account of capability and health, the range of health capabilities can vary from the most elementary to more complex, as illustrated in Figure 1.

The Aristotelian view as well as the capability perspective allow for people to make choices in accordance with their own conceptions of the good. Both Sen and Nussbaum distinguish between functioning and capability by employing the example of starving versus fasting. The two conditions represent different capability sets. “It is possible to attach importance to having opportunities that are not taken up,” Sen notes.¹⁰⁰

The capability approach’s second major component is that considering human heterogeneity¹⁰¹ is central to assessing equality. Sen argues that humans have diverse internal characteristics (e.g., age, sex, health status, physical stature, and mental attitude) and external characteristics (e.g., geographical environments, social norms, familial levels of wealth and education) that should inform the assessment of equality, especially because equality requires society to aid those in proportion to their degree of disadvantage. This point is particularly important for justifying the positive freedoms that all should enjoy and the societal obligation to provide individuals with needed resources to improve their capability to function. Like Nussbaum, Sen notes that this idea contrasts with the Rawlsian focus on primary goods, which fails to consider the different effects of the same bundle of goods on different people.

The emphasis on heterogeneity pertains to a right to health and health policy because it provides a rationale for treating individuals differently. For example, children require different resources than adults to achieve optimal physical and mental functioning. Thus, a newborn with pneumonia may require hospitalization, antibiotics, and defensive monitoring, whereas an adult would likely regain full pulmonary function with no hospitalization and low dosages of antibiotics. Similarly, a person with a disability would require more resources than one without a disability to achieve the same capability to function, as when a man in a wheelchair needs an appropriately-designed ramp to get into his workplace. Consider also the nutritional requirements of children, who need different types of calories than adults because they are growing, and pregnant women, who must take in adequate quantities of certain vitamins (e.g., folic acid) and nutrients to ensure normal fetal development. As Dreze and Sen show, the relationship between food intake and nutritional

99. *Id.* at 76.

100. *Id.*

101. SEN, *supra* note 43, at 1.

adequacy varies greatly with metabolic rate, body size, gender, pregnancy, age, climate, epidemiological characteristics, and other factors.¹⁰² Thus, interpersonal and inter-social variations affect the relationship between resources and capabilities.

A third major component of the capability approach is that preferences or desires, in and of themselves, are not suitable indicators of well-being. Instead, the capability to achieve valuable functionings should be the main variable for evaluation. In particular, employing utilities to judge consequent states of functioning is problematic because “the mental metrics [such as] pleasure or desire”¹⁰³ are subjective and changeable. They are not robust measures of deprivation and disadvantage. Others have expressed concerns about the subjectivity of utilitarianism.¹⁰⁴

Most importantly, on an account of capability and health, using preferences or utilities to evaluate health interventions will not necessarily produce allocations that serve the array of health functionings, health needs, and health capabilities in a given society. Health preferences might be weak or health utilities might be low for certain objectively important health functionings; for example, in some cultures, devaluation of women might diminish preferences for maternal health during and after pregnancy. In these cases, allocations will differ from those based on health capabilities, which invoke health functionings and health needs as objectively important criteria for resource allocation. So, on this view, safe motherhood in all countries is valued as an essential human functioning. Functionings, as opposed to utilities or preferences, also may lend themselves better to interpersonal comparison. And, as Sen notes, many types of functionings can be “seen distinctly from their mental assessment.”¹⁰⁵

A fourth major component of the capability approach is that freedom involves at least two elements: opportunity and process. The opportunity aspect judges public policy in terms of its impact on individuals’ substantive freedoms or capabilities to choose a life they have reason to value. Thus, public policy must be concerned with the opportunities individuals have to achieve valued outcomes. Applying this to health, health policies would be evaluated by their impact on individuals’ health capabilities and health functionings, selected and rated according to

102. JEAN DREZE & AMARTYA K. SEN, *HUNGER AND PUBLIC ACTION* (1989).

103. SEN, *supra* note 93, at 63.

104. Dan Brock, in particular, has focused on how different health states should be valued, differences in evaluations among different groups (e.g., disabled versus non-disabled), methods for preference elicitation, whose values to use and whether or not to discount utilities. See Dan W. Brock, *Justice and the ADA: Does Prioritizing and Rationing Healthcare Discriminate Against the Disabled?*, 12 *SOC. PHIL. & POL’Y* 159 (1995); Dan W. Brock, *Quality of Life Measures in Health Care and Medical Ethics*, in *THE QUALITY OF LIFE*, *supra* note 69, at 46.

105. SEN, *supra* note 93, at 76.

generally accepted standards, as discussed in Part IV.

The process for articulating this goal and agreeing on how to achieve it relates to the second aspect of freedom. The process aspect makes public participation in political decisions and social choice a constitutive part of public policy. Sen argues that such participation has three main roles: direct, instrumental, and constructive. It is instrumental, he argues, because “informed and unregimented formation of our values requires openness of communication and arguments”¹⁰⁶ It is constructive, he continues, because public discussion and debate helps participants understand needs and conceptualize solutions. “These processes are crucial to the formation of values and priorities,” Sen notes, and “we cannot, in general, take preferences as given independently of public discussion.”¹⁰⁷ This third aspect of decision-making bears particularly on health policy because it requires agreement on individuals’ capabilities and functionings and the necessary requirements for a flourishing life. Developing institutions to maintain and improve health should reflect the influence of the public participating in social choice and decision-making.

The process-oriented emphasis of the capability approach stems in part from the elementary focus on individuals’ “agency” or ability to understand and shape “their own destiny and help each other.”¹⁰⁸ The approach focuses primarily on “the individual as a member of the public and as a participant in economic, social and political actions.”¹⁰⁹ Applying this principle to health, one would need to account for information asymmetry and the fact that individuals might need assistance from experts. In this case, as with the Aristotelian view, there would also be a role for physicians to share decision-making with patients. Enabling patients to make their own decisions as agents of their own health, however, is essential.¹¹⁰

1. Selection and Valuation

The capability approach requires selecting and valuing capabilities to assess public policy. The capability approach leaves the specification of valued objects (selecting and determining relative weights of functionings) partly open because the deliberative process must be explicit and open. It requires agreement among individuals on the selection and weighting of different functionings and capabilities, thus involving them in decisions

106. *Id.* at 152.

107. *Id.* at 153.

108. *Id.* at 11.

109. *Id.* at 19.

110. For further discussion on the extent to which society supports health agency so that individuals can convert health care resources into health functionings, see Jennifer Prah Ruger, *Rethinking Equal Access: Agency, Quality and Norms*, 2 GLOBAL PUB. HEALTH 24, 25 (forthcoming 2006).

that affect them and generating a reasoned consensus specific on a range of weights. However, the capability approach is not fully indeterminate either. It acknowledges some universally shared objectives, but resists a single unique social ordering. Sen offers the option of defining certain functionings contextually. One example is social functioning because the capabilities for “being able to appear in public without shame vary greatly from one community to another.”¹¹¹

On valuation and weighting, Sen’s primary criterion is well-being as measured by functioning and capabilities: “It is in asserting the need to examine the value of functionings and capabilities as opposed to confining attention to the means to these achievements and freedoms (such as resources or primary goods or incomes) that the capability approach has something to offer.”¹¹² The capability approach espouses variations in weights that different people attach to different functionings.¹¹³ It leaves partly open (1) the choice of value-objects—the class of functionings necessary for measuring capabilities, and (2) the relative weights or range of weights given to functionings in evaluating capabilities. “This is a ‘social choice’ exercise,” Sen notes, “and it requires public discussion and a democratic understanding and acceptance.”¹¹⁴ Sen does, however, emphasize that operationalizing the approach requires identifying valuable capabilities and ranking them.

In some evaluative exercises, the capability approach does separate out a subset of basic capabilities—elementary and crucially important functionings up to minimally adequate levels. Sen has argued for his own selection and partial ranking in assessing equality in terms of fulfilling certain basic capabilities in environments of elementary deprivation, although the capability approach is not confined to basic capabilities. Sen’s notion of “basic capabilities” is such that justice requires raising people *above* a certain threshold level. In later works he defines a set of five categories of fundamental freedoms: social opportunities, economic facilities, political freedom, transparency guarantees, and protective security.¹¹⁵

Other major claims of the capability approach—incomplete specification and partial ordering—are important for understanding the demands of equality in public policy, health policy, and law. Both tend to be more procedural than substantive, focused primarily on achieving consensus in identifying and prioritizing valuable capabilities and the means to achieving those capabilities. The focus on basic capabilities that

111. Amartya K. Sen, *Capability and Well-Being*, in *THE QUALITY OF LIFE*, *supra* note 69, at 47.

112. SEN, *supra* note 43, at 46.

113. Sen, *supra* note 111, at 31-32.

114. SEN, *supra* note 93, at 79.

115. *Id.* at 127.

are essential or fundamental to human flourishing is an example of incomplete specification. It helps us to prioritize certain capabilities and to determine which are universally accepted objectives, even though other capabilities are unspecified. The capabilities to avoid premature mortality and escapable morbidity fall into this category.¹¹⁶

The second aspect—partial ordering—specifies that not all dimensions of a construct need be fully ordered and weighted for every social evaluation. Here, employing the procedure he calls “dominance partial ordering,” Sen shows that the capability approach can identify a certain subset of functionings or capabilities as valuable, without requiring agreement on the relative weights to be attached to those capabilities. Applying this process to health, one might say that if freedom from under-five mortality and freedom from contracting AIDS are both deemed valuable, it is unnecessary at the first stage of ranking to determine the exact relative weights to attach to those freedoms. Having both freedoms is valuable; quantifying how valuable at this first stage is less important.

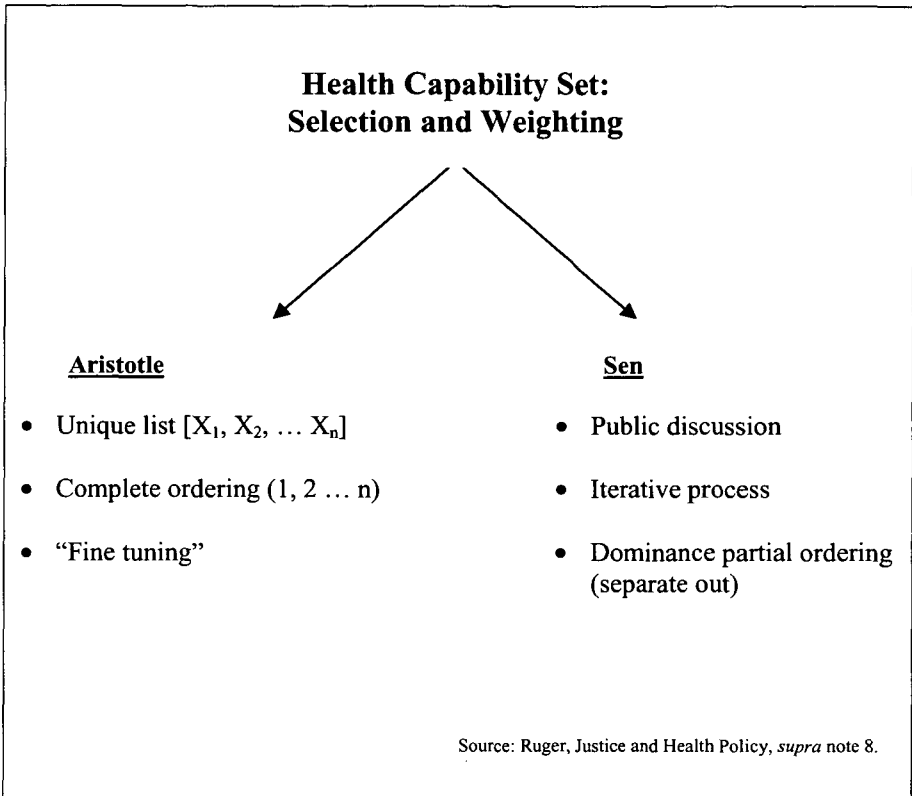
The selection and weighting of capabilities should be, however, an iterative process for providing a certain level of basic functioning before addressing inequalities in less important capabilities. Fine-tuning a complete ordering with exactitude is unnecessary. As Sen notes, “[P]artial agreements still separate out acceptable options (and weed out unacceptable ones), and a workable solution can be based on the contingent acceptance of particular provisions, without demanding complete social unanimity.”¹¹⁷ The ideas of incomplete ordering and partial agreement apply to the selection of social arrangements, policies, programs, and interventions as well. As Sen notes, “[I]t is also important to recognize that agreed social arrangements and adequate public policies do not require that there be a unique ‘social ordering’ that completely ranks all the alternative social possibilities.”¹¹⁸ Figure 2 illustrates the general differences between Aristotle and Sen as applied here to the selection and weighting of health capabilities.

116. See Ruger, *Aristotelian Justice*, *supra* note 8, at 108-112 (where I argue that while we should prioritize and meet the health needs associated with central health capabilities above other health capabilities, as prior or prerequisite to other capabilities, the selection and weights among non-central health capabilities would be left to further specification through social agreement).

117. SEN, *supra* note 93, at 253.

118. *Id.*

Figure 2: Selection and Weighting of Health Capabilities



In Part III, I argue that the incompletely theorized agreements (ITA) framework helps extend the capability approach when “dominance partial ordering” and incomplete specification fail to provide reasonable procedures for resolving conflict among different views. I suggest that the capability approach needs such a framework for social choice. ITA thus picks up where the capability approach leaves off, providing a framework for resolving conflict among divergent views. No unique view of health or health capabilities exists. The incomplete, partial ordering of the capability approach combined with incompletely theorized agreement on that ordering allows for reasoned public policy decision-making.

2. *Basic*¹¹⁹ and *Central*¹²⁰ Capabilities

To distinguish between varying capabilities, Sen finds it useful, as noted above, to identify a subset of capabilities “dealing with . . . ‘basic needs.’”¹²¹ These capabilities are critical because, if they are unavailable, most other capabilities are inaccessible. These capabilities are essentially prerequisites to other capabilities. There is a fair amount of agreement on the “extreme urgency of a class of needs,”¹²² claims with “particular moral and political importance.”¹²³ But as Sen notes, the basic needs literature¹²⁴ focuses more on resources than on human beings, a focus that hinders the assessment of how resources affect people’s ability to function. The capability view accepts the basic needs concept but stresses choice and individuals’ ability to make their own decisions.¹²⁵

I have argued for a distinction between central and non-central health capabilities to extend this concept to health policy: central health capabilities are a particular subset of health capabilities (see Figure 3 below), which, being prerequisites for other capabilities, take priority over non-central health capabilities in evaluating health policies.¹²⁶ These capabilities can be seen as prerequisites for other capabilities, such as developing abilities, using talents, and carrying out plans.¹²⁷ These essential elements of health are universally shared objectives.

119. Sen uses the term basic capabilities to “separate out the ability to satisfy certain elementary and crucially important functionings up to certain levels.” SEN, *supra* note 43, at 45. Nussbaum also uses the term basic capabilities, but refers to them as innate capabilities (such as practical reason and imagination). See *Political Distribution*, *supra* note 63.

120. For more on the distinction between central and non-central health capabilities, see Ruger, *Aristotelian Justice*, *supra* note 8 at 108-112. Nussbaum has also discussed what she calls “the central human capabilities” as “those human capabilities that can be convincingly argued to be of central importance in any human life, whatever else the person pursues or chooses.” Nussbaum, *supra* note 26, at 286.

121. Sen, *supra* note 111, at 40.

122. *Id.*; see also SEN, *supra* note 43; WORLD BANK, *WORLD DEVELOPMENT REPORT: POVERTY* (1990) [hereinafter *WORLD BANK, POVERTY*]; WORLD BANK, *WORLD DEVELOPMENT REPORT: THE STATE IN A CHANGING WORLD* (1997) [hereinafter *WORLD BANK, CHANGING WORLD*]; Sudhir Anand & Amartya K. Sen, *Sustainable Human Development: Concepts and Priorities* (Human Development Report Office Occasional Papers No. 1994-1, 1994).

123. Sen, *supra* note 111, at 40.

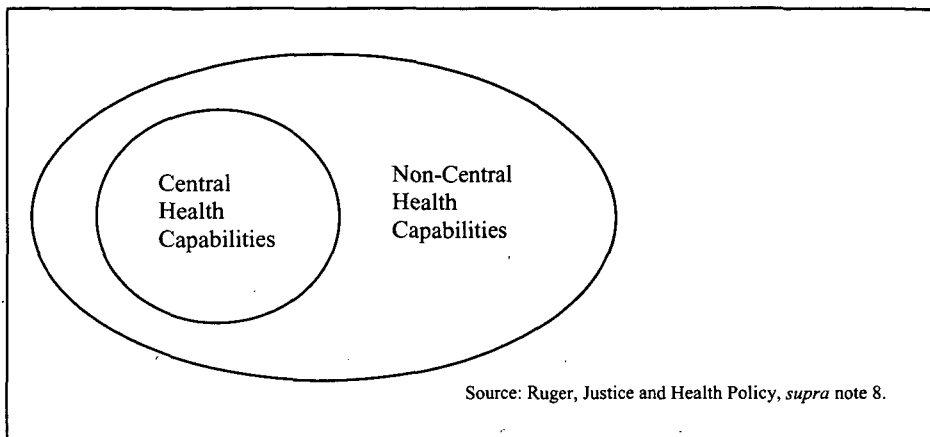
124. See PAUL STREETEN, *FIRST THING FIRST: MEETING BASIC NEEDS IN DEVELOPING COUNTRIES* (1981), on the “basic needs” literature.

125. Nussbaum, *Good as Discipline*, *supra* note 63, at 12.

126. Ruger, *Aristotelian Justice*, *supra* note 8, at 108-112.

127. WORLD BANK, *POVERTY*, *supra* note 122, at 11.

Figure 3: Health Capabilities



To operationalize a right to health, determining how to measure capabilities and at what levels to provide them is necessary. Health capabilities evaluation can use “realized functionings” (what a person actually does) and her possible alternatives (real opportunities or what a person is free to do).¹²⁸ Functionings and capabilities are related, Sen notes, in that a person’s capability refers to the alternative combinations of functionings that she might achieve. Thus, capability includes “the substantive freedom to achieve alternative functioning combinations.”¹²⁹ Capability, in its *potential* sense, is thus not directly observable or measurable, but constitutes an ability for functioning represented by options for alternative functionings. On an account of capability and health, to evaluate health policy, one may still assess *realized* health functionings (e.g., physical and mental functionings) to view individuals’ health capabilities.¹³⁰ However, one must also assess a person’s *potential* health achievement, especially relevant when considering preexisting illness and disability. Health capabilities constitute individuals’ *abilities* to achieve health functionings.¹³¹ The overall set of health capabilities represents a

128. SEN, *supra* note 93, at 75.

129. *Id.*

130. Measures for assessing realized health functionings linked to central health capabilities in many respects already exist. These include life expectancy, infant and child mortality, and prevalence and incidence rates of disease (e.g., tuberculosis and polio), dysfunction (e.g., infertility), and physical and mental functioning and disability (e.g., paraplegia, unable to climb stairs, manic depression). For further discussion of indicators to employ in measuring realized functionings linked to central health capabilities see Ruger, *Aristotelian Justice*, *supra* note 8, at 111-112.

131. It is worth clarifying here the difference between health capabilities that relate to health functionings and talents and skills that may be associated with the broader set of capabilities. Talents and skills, of course, reflect and impact individuals’ accomplishments, overall achievements, and opportunities in life. At some level talents and skills do affect one’s health capabilities, and *vice versa*,

person's overall freedom to achieve health functionings. I return to these issues in Part IV.

III. PLURALISM, INCOMPLETELY THEORIZED AGREEMENTS, AND PUBLIC POLICY

A. *Incompletely Theorized Agreements*

In applying the capability view to health, health policy, and the right to health, two questions are significant: (1) how to obtain collective agreement on a dominance partial ordering of capabilities; and (2) what type of social decision-making might apply in such an exercise. For this phase of the work I argue that the incompletely theorized agreements approach holds promise as a complementary framework for the Aristotelian and capability views.¹³²

The theory of incompletely theorized agreements (ITA), developed by Cass Sunstein,¹³³ has been applied generally in law as a descriptive and normative framework of legal, and specifically judicial, decision-making, but has not been applied to specific policy areas, such as health. An incompletely theorized agreement is one that is not uniformly theorized at all levels, from high level justifications to low level particulars. Incompletely theorized agreements fail to produce depth (full accounts of foundations) or width (coherence with other dimensions), an idea that relates somewhat to John Rawls's notion of *overlapping consensus*.¹³⁴

Both Rawls and Sunstein attempt to bring about stability and social agreement—the resolution of social disputes—among people who disagree on fundamental matters. Rawls asserts that people who disagree on “comprehensive views” can agree on certain political abstractions and can converge enough for political decision-making.¹³⁵ According to Rawls, social accord can be achieved in a democracy through shared

but given the rather narrow focus of this analysis on health capabilities, the issue of differential talents and skills is not highly relevant. (This issue did come up, however, in Daniels' fair equal opportunity account. See DANIELS, *supra* note 9.) In the account of capability and health presented here and elsewhere, talents and skills are taken to be more-or-less constant or fixed—neither is the *direct* object of health policy actions or assessments. Health knowledge and health-related skills are appropriate foci, however, as I argue in Jennifer Prah Ruger, *Health Capability: Conceptualization and Operationalization* (March 23, 2006) (unpublished manuscript, on file with the author).

132. It is important to note, before moving on, that the ITA framework is applied here *only* to one point of the capability view—that of the social choice exercise of coming to agreement on a partial order of capabilities—thus it is important to think about the use of ITA in this framework as one aspect of the theoretical framework advanced in this Article and to confine its use in terms of its complementarity, rather than substitutability, with the capability perspectives. I also do not rely on a specific account of either the ITA or capability view.

133. Cass Sunstein, *Incompletely Theorized Agreements*, 108 HARV. L. REV. 1733 (1995).

134. JOHN RAWLS, *POLITICAL LIBERALISM* (1993).

135. *Id.* at 134-173.

commitment to abstract principles.¹³⁶

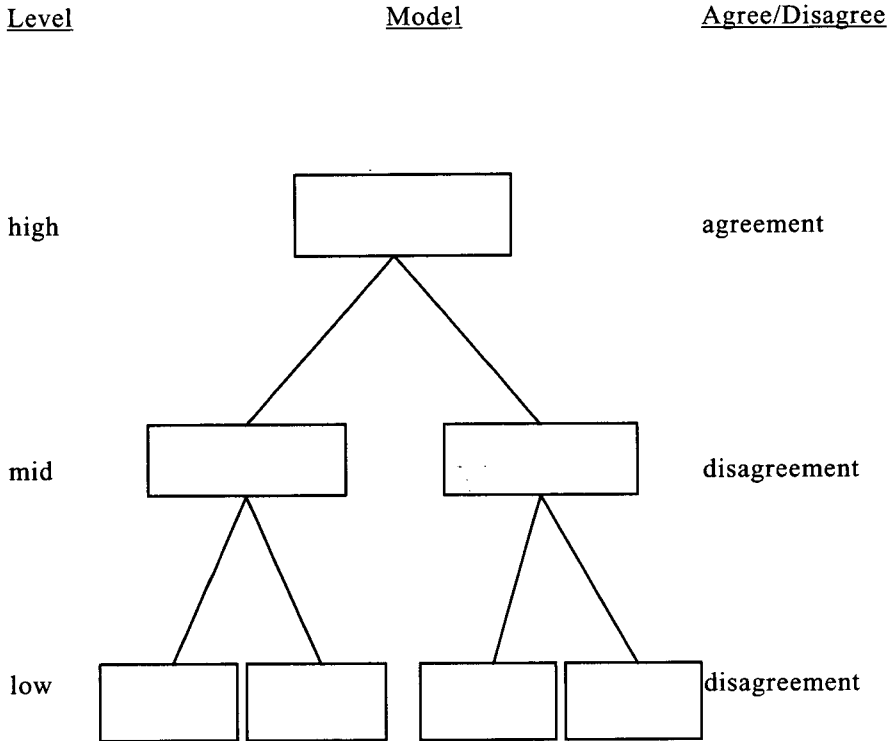
The ITA approach contrasts, in part, with the Rawlsian program. ITA concedes that agreement on abstract political principles can produce stability, social agreement, and in defining political moments, social reform. But it argues that this type of agreement is less useful for legal purposes and for ordinary politics because of its focus on large questions of political philosophy. These larger questions, Sunstein argues, are less relevant to ordinary political and legal decision-making than are questions of particulars.

High level principles can have an important role in democratic political life generally and in major social movements specifically. Decision-making in public policy settings, however, requires reasoned agreement on particular outcomes, regardless of whether there is agreement on political abstractions. Legal decision-making has to produce agreement on particular outcomes; and because there rarely is agreement on high-level principles, those particular outcomes must be justified by low level principles. People can disagree on general principles but agree on concrete cases. Lawyers and judges are more likely to converge on lower levels of abstraction than higher ones—dealing with necessary decisions of “what to do rather than what to think.”¹³⁷ This approach is therefore more appropriate for well-functioning legal systems in democratic societies.

Sunstein’s incomplete theorization typology is usefully applied to decision-making about health and health policy. I created diagrams to capture the three types of incompletely theorized agreements: incompletely specified agreements (Figure 4), incompletely specified and generalized agreements (Figure 5), and incompletely theorized agreements on particular outcomes (Figure 6) to help illustrate this point.

136. *Id.*

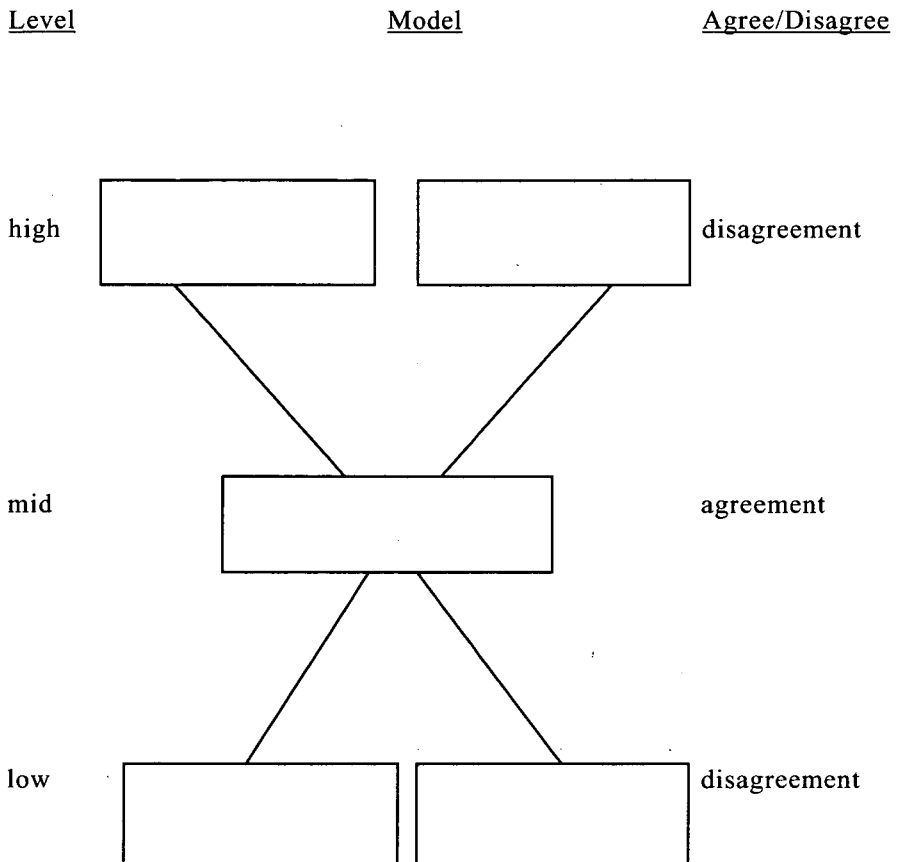
137. Sunstein, *supra* note 133, at 1736 n.8.

Figure 4**MODEL ONE: INCOMPLETELY SPECIFIED AGREEMENTS
(HIGH-LEVEL AGREEMENT)**

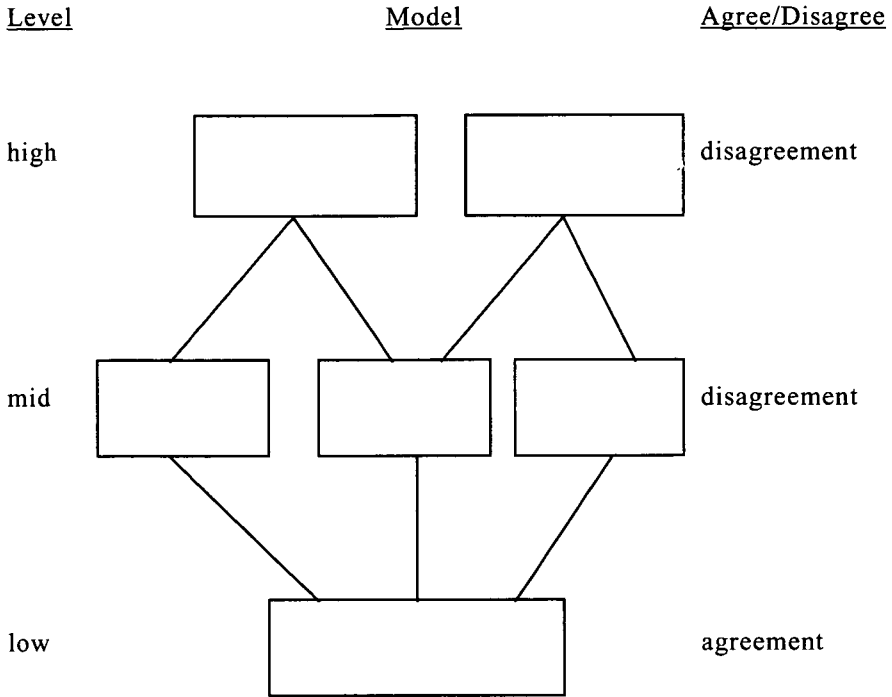
Source: Ruger, *Aristotelian Justice*, *supra* note 8, at 105.

Figure 5

MODEL TWO: INCOMPLETELY SPECIFIED AND GENERALIZED AGREEMENTS (MID-LEVEL AGREEMENT)



Source: Ruger, *Aristotelian Justice*, *supra* note 8, at 106.

Figure 6**MODEL THREE: INCOMPLETELY THEORIZED AGREEMENTS ON PARTICULAR OUTCOMES (LOW-LEVEL AGREEMENT)**

Source: Ruger, *Aristotelian Justice*, *supra* note 8, at 107.

B. Incompletely Specified Agreements

The first type of incompletely theorized agreement occurs when there is agreement on a general principle, accompanied by sharp disagreement about particular cases. Here, Sunstein argues, people who accept a general principle—murder is wrong, for instance—need not agree on what this principle entails in particular cases—e.g. abortion.¹³⁸ Similarly, I argue, people who accept the general principle of good health may disagree on what good health requires in provision of health care and other concrete social services.

138. *Id.* at 1739.

C. Incompletely Specified and Generalized Agreements

The second type of incomplete theorization occurs when people agree on a mid-level principle, but disagree both about the more general theory that accounts for it and about outcomes in particular controversies. Here, Sunstein states that the connections are unclear both between the general theory and mid-level principles and between specific cases and mid-level principles.¹³⁹ As a health example, I argue, people might agree on universal health insurance coverage without settling on a large-scale theory of equality or on a specific health plan. In this model, there is a great deal of uncertainty and ambiguity leading to more divergence than convergence.¹⁴⁰

D. Incompletely Theorized Agreements on Particular Outcomes

Incompletely theorized agreements on particular outcomes involves, in a public policy and human rights context, how people make decisions and come to agreement on particular policy options. In this model, parties reach agreement on low-level principles that do not necessarily derive from one particular high-level theory. In other words, low-level principles may be compatible with more than one high-level principle. People may agree on individual judgments while disagreeing on the level of general principle.

E. Incompletely Theorized Agreements and Public Policy

While the ITA framework has been applied generally in law, I have argued that it also has promise as a descriptive and normative analytical framework for public policy,¹⁴¹ and now for human rights. In applying the ITA framework in a human rights or public policy setting, at least two points are important: (1) the approach is well suited to human goods that are plural and ambiguous; and (2) it allows for different but converging paths to the same agreement. In matters of public philosophy concerning inherently plural and indistinct concepts, and in dealing with collective choice involving numerous views and disagreements, ITA can help bring participants in a public policy and human rights discussion to agreement on certain specific outcomes.

In social decision-making about health capabilities, health policy, and a right to health, the ITA framework is particularly useful and complementary to the capability approach in at least three important respects. First, health, and thus health capabilities are multi-dimensional

139. *Id.*

140. For further discussion of an analysis of US health care reform from the perspective of value-based arguments of different levels of generality, see generally Ruger, *supra* note 29.

141. Ruger, Aristotelian Justice, *supra* note 8, at 88-107.

concepts about which different people have different and sometimes conflicting views. Complete theorization is thus difficult to achieve. No unique view of health or health capabilities exists. No view is ideal or unanimously agreed upon for all evaluative purposes. Second, the incomplete, partial ordering of the capability approach combined with incompletely theorized agreement on that ordering allows for reasoned public policy decision-making in particular situations. Third, given the demands of certain evaluative exercises, in particular human rights and public policy contexts, the flexibility of these approaches allows reasoned agreement on central aspects of health and capabilities, without requiring agreement on non-central aspects. It also allows for different paths to the same conclusion.

F. Pluralism, Ambiguity, and Incompletely Theorized Agreements

Often in decision-making settings people “can know that something is true without entirely knowing why this something is true.”¹⁴² Consider these instances: people might agree that murder is wrong, that the government should prevent famines, that society should not let people starve and die in the streets, that we should try to prevent the spread of communicable diseases, and that people should not be subject to forced genital mutilation. People can hold these views without knowing exactly why. For example, in Oregon’s Medicaid experiment,¹⁴³ there was substantial agreement that cystic fibrosis and viral pneumonia claimed allocational priority in providing medical care over tooth-capping, acute headaches, and thumb-sucking. But people did not generally agree on or know exactly why this should be the case. In hospital emergency rooms, physicians will agree on triage decisions prioritizing life-saving interventions over quality of life enhancements, without fully theorizing why. And in certain applications of the capability approach, there is considerable agreement on urgent basic needs without a full understanding of the reason.

The need for reasoned public policy in the face of these ambiguities makes the ITA approach appealing especially in the context of human rights. Like many concepts in human rights, “health” and “human flourishing” are multidimensional and ambiguous. Still, people can understand the concepts of “health” or “human flourishing” or “capability” without fully articulating their details. Through these partially theorized concepts, humans can judge and evaluate policy as desirable or undesirable.

The ITA theory allows people to agree on an outcome despite these

142. Sunstein, *supra* note 133, at 1742.

143. U.S. OFFICE OF TECH. ASSESSMENT, EVALUATION OF OREGON MEDICAID PROPOSAL OTA-H-531 (1992).

ambiguities. Decision-makers need not fully share a common set of foundations for their beliefs and are allowed to leave unarticulated the “right” reasons for their respective convictions. When their convergence over a human right is incompletely theorized, it enables them to obtain some clarity and decisiveness in the result without precisely specifying their reasons for it.

G. Incompletely Theorized Agreements and Capability

I return here to obtaining collective agreement on the selection and weighting of health capabilities for evaluating the right to health. The ITA framework complements the capability approach in this phase because it allows for collective agreement on a dominance partial ordering of capabilities without requiring that political participants agree on other capabilities. It can thus obtain agreement on the dominance partial ordering of basic or central capabilities without requiring agreement on non-basic or non-central capabilities as noted in Part II above.

The ITA framework also assumes pluralism in many forms. Plural value structure and plural agents do not upset the framework so long as there are at least some areas of consensus. In this sense it allows the capability approach to apply more widely. As Sunstein notes, “People value things not just in terms of weight, but also in qualitatively different ways. Human goods are plural and diverse, and they cannot be ranked along any unitary scale without doing violence to our understanding of the qualitative differences among those very goods.”¹⁴⁴

Applying the ITA framework to questions of health, health capability, and health policy, one sees that people can agree on particular outcomes. Individuals can agree, for instance, on those health capabilities that are essential to a right to health and the low-level principles that justify them without agreeing on complete answers to metaphysical questions, such as “what is human flourishing” or “what is health?”

In summary, in the context of a political or social discussion, the ITA framework allows for complete decisions on agreed and theorized incomplete orderings, a central aspect of the capability approach. In a liberal democratic society, it is important to see the essential connection between the exercise of civil liberties through political participation and practical policy decisions. The ITA framework illuminates that connection and holds promise for progress toward a “right to health.” The next section applies this framework, in combination with the capability view, to define the scope and content of a right to health.

144. Sunstein, *supra* note 133, at 1742.

IV. SCOPE AND CONTENT OF A RIGHT TO HEALTH

One of the greatest obstacles to operationalizing a right to health is determining the scope and content of such a right. As Larry Gostin notes, “A right to health that is too broadly defined lacks clear content and is less likely to have a meaningful effect.”¹⁴⁵ The World Health Organization definition of health, for example, is so broad as to constitute an unreasonable standard for human rights, policy, and law. It is certainly difficult to implement and adjudicate.¹⁴⁶ But defining a human right to health is necessary for delineating obligations of state and non-state actors, including individuals, and to identify violations and guidelines for enforcement.

This section is divided into two overarching themes: the first presents an idea of health that is useful as a guiding consensus in implementing the right to health. The second argues for the ethical and social claims on others—state, non-state actors, groups, and individuals—that might be enshrined in domestic policy and law. It especially asserts the need for all individuals to *internalize the public moral norm* of equity in health, to understand the obligations each of us has to help realize the right to health for every individual in the global community. For positive rights, such as the right to health, this internalization process must entail a commitment to financial claims (e.g., tax contribution) to respect and fulfill the right (e.g., through universal health insurance coverage). Internalizing the norm on an individual basis will ultimately lead to public policies, legislation, and agreed-upon laws, which will enhance the prospects of fulfilling a right to health obligation.

A. Trans-Positionality: A Global View of the Right to Health

The capability approach calls for efforts to construct what Sen calls “trans-positionally” consistent or “global” points of view on various crucially important functionings.¹⁴⁷ Thus this Article seeks a globally shared standard of “health” upon which to make interpersonal comparisons of health capabilities. The demands of social justice and the right to health require a universally shared norm of health in order to establish a framework for making interpersonal comparisons. The capability approach (specifically in its emphasis on what Sen calls “basic capabilities”), clearly promotes objectively assessed health (e.g., mortality and morbidity) as a universally valued capability. Thus the challenge is to construct a conception of health that reflects the “view from

145. Gostin, *supra* note 5, at 29.

146. *Id.*

147. Sen, *supra* note 30, at 130.

everywhere.”¹⁴⁸

There has been some discussion in the philosophical, medical, and human rights literature about how to define health and its most important dimensions. General Comment 14 of the International Covenant on Social, Economic, and Cultural Rights provides a definition of health and the goal of a right to health as “the highest attainable standard of mental and physical health.”¹⁴⁹ It did not elaborate, however, on different accounts of health or the meaning of a high attainable standard in a world of diverse individuals with variable genetic and biological capacity. While no unanimous account of health exists, it might be possible to isolate certain central agreed-upon features for assessing political arrangements. This section focuses on deriving a practical, agreed-upon, and clear account of health for the analysis of ethical and social obligations under a right to health.

Concepts such as “health” or “quality of life” cannot claim to have a meaning that can be validated by reference to an external source. Such concepts entail a degree of social and cultural construction, with different meanings across time and place. Society must decide which different possibilities are important. Still, as Thomas Scanlon argues, there is merit in searching for a substantive-enough account against which activities can be assessed so that it can serve as a basis for criticism of certain injustices and oppression in the world.¹⁵⁰

This line of reasoning calls for thinking about concepts such as human functioning and health in a more universal and critical way. Even communitarians like Michael Walzer¹⁵¹ and others maintain that while “objectivity” might not exist, it is important to take note of the criticism that exists within a given culture to understand what good health or good functioning might entail. And while there may be no unanimous or unique account of health, it is possible to isolate certain primary defining features of health and human life to which we assign priority for assessing political arrangements.

Sen’s focus on “positional objectivity”—the notion that some assessments of social affairs can be made with a certain degree of objectivity once individuals’ circumstances are taken into account¹⁵²—underscores the need for a more objective account of health. A “transpositional” or more “global” point of view is useful both in assessing equity and efficiency in public policy and in interpreting the right to

148. *Id.* at 126

149. The Right to the Highest Attainable Standard of Health, CESCR General Comment 14, U.N. CESCR, 22d Sess., U.N. Doc. E/C.12/2000/4 (2000).

150. Thomas Scanlon, *Preferences and Urgency*, 72 J. PHIL. 655, 660 (1975).

151. MICHAEL WALZER, *SPHERES OF JUSTICE* (1983); Michael Walzer, *Objectivity and Social Meaning*, in *THE QUALITY OF LIFE*, *supra* note 69, at 165.

152. Sen, *supra* note 30, at 130.

health. Subjective reports of health can fail to reveal health deprivations. Sen found this discrepancy when examining differences in mortality and self-reported illness between men and women in India. Even though women had higher rates of morbidity than men, they reported poor health less often.¹⁵³ Sen recognized that “positional” assessments of health by individuals themselves, resting on inadequate medical knowledge and cultural attitudes devaluing women’s lives and health vis-à-vis men, could lead to misallocation of resources away from those with bonafide health needs. In an account of capability and health, health needs¹⁵⁴ map directly to health functionings, which in turn relate to health capabilities. Thus, health needs are objective measures of our success in improving health capabilities. The task, then, is to specify health needs as they relate to health functionings and health capabilities. The concept of medical necessity and medical appropriateness must also be considered.¹⁵⁵

The literature defining health is varied and contentious. On one end of the spectrum are particularly narrow views, adhering to the so-called biomedical model of health, that define health as the “absence of diseases or abnormalities of the organ tissues or biological processes.”¹⁵⁶ Illness represents deviations from biological norms. Concepts such as wellness, well-being, or functional effectiveness (a person’s ability to perform activities of daily life) sometimes, but not always, fall within these narrower views.¹⁵⁷ On the other end of the spectrum are definitions that are so broad as to include all of what might be included in the concept of quality of life.

Numerous scholars and practitioners have exhaustively reviewed the literature and practice on conceptualizing and operationalizing health, and in particular look to the health status measurement literature and practice

153. *Id.* at 130.

154. The broader concept of needs is difficult to fully determine without ambiguity. For some clarification, I invoke the definition of need characterized by Beauchamp and Childress as a material principle of justice. See BEAUCHAMP & CHILDRESS, *supra* note 34, at 329-30. In their work, Beauchamp and Childress note that a person needs something when without that something the person will be harmed or at least detrimentally affected. Fundamental needs are differentiated from non-fundamental needs. A person with a fundamental need for something will be harmed or detrimentally affected in a fundamental way without that good or service. I consider the notion of fundamental needs to be more or less equivalent to that of basic needs. For example, a person might be harmed through malnutrition or by having a heart attack or by breaking his leg. Through its link to health capabilities, the notion of health needs—and the most fundamental or basic needs—is justified, specified, and further refined into a basis for justice and resource allocation in health policy. Health needs, through the notion of functioning, define what it is that is required to improve individuals’ health capabilities. Improving individuals’ health capabilities requires preventing, curing, and compensating for conditions that curtail individuals’ capabilities for health functioning. Elsewhere I augment health needs with requirements of medical necessity and medical appropriateness for health resource allocation. See generally, Ruger, *supra* note 31.

155. See e.g., Ruger, *supra* note 31, at Section IV.C.5-IV.C.7

156. Debra J. Lerner & Sol Levine, *Health Related Quality of Life: Origins, Gaps, and Directions*, in ADVANCES IN MEDICAL SOCIOLOGY 44 (Ray Fitzpatrick ed., 1994).

157. *Id.*

for alternative models. After studying 322 patients over age eighteen, researchers postulated that functional status has two dimensions, physical and psychosocial, the latter strongly related to depression and other mental illnesses.¹⁵⁸ Hays and Stewart¹⁵⁹ surveyed 1980 patients in the Medical Outcomes Study using a concept of health that also had two dimensions: physical (role limitations due to physical health, physical function, satisfaction with physical ability, and mobility) and mental (depression, behavioral emotional control, positive affect, anxiety, feelings of belonging).

Lohr, Mock, and Ware¹⁶⁰ expanded these conceptions by attributing four dimensions to health: physical, mental and emotional, everyday functioning in social and role activities, and general sense of well-being and vitality. Ware's version of the concept¹⁶¹ is similar, emphasizing four health components—physical, mental, social and role functioning, and general health perceptions. Manning¹⁶² delineated the four aspects of health as physical, mental, social, and physiological. Englehardt¹⁶³ used a more normative approach, regarding poor health and disease as deviations from the social norm as well as from the biological blueprint. In a study of 801 elderly people from Ohio and 1025 from Virginia, Whitelaw and Liang¹⁶⁴ defined three dimensions of health: physical (chronic illness, functional limitation, self-rated health), mental (depression, anxiety, positive well-being, self-rated health), and social (social contacts, emotional support, and instrumental support).

In 1947, the World Health Organization defined health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.”¹⁶⁵ Since that time, a number of scholars in health policy and the medical sciences have broadened that definition of health with concepts that are very close to well-being and quality of life.¹⁶⁶ While this sample is not exhaustive, it illustrates the broad variations in

158. W. Blair Brooks et al., *The Impact of Psychologic Factors on Measurement of Functional Status*, 28 MED. CARE 793 (1990).

159. Ron D. Hays & Anita L. Stewart, *The Structure of Self-Reported Health in Chronic Disease Patients*, 2 PSYCHOL. ASSESSMENT 22 (1990).

160. KATHLEEN N. LOHR & GREGORY A. MOCK, ADVANCES IN THE ASSESSMENT OF HEALTH STATUS (1989); John E. Ware, *Measuring Functioning, Well-being, and Other Generic Health Concepts*, in EFFECT OF CANCER ON QUALITY OF LIFE (D. Osaba ed., 1991).

161. Ware, *supra* note 160.

162. Willard G. Manning et al., *The Status of Health in Demand Estimation: Or, Beyond Excellent, Good, Fair, Poor*, in ECONOMIC ASPECTS OF HEALTH 143 (Victor R. Fuchs ed., 1982).

163. H. Tristram Engelhardt Jr., *The Disease of Masturbation: Values and the Concept of Disease*, 48 BULL. HIST. MED. 234 (1974).

164. Nancy A. Whitelaw & Jersey Liang, *The Structure of the OARS Physical Health Measures*, 29 MED. CARE 332 (1991).

165. Constitution of the World Health Organization pmb. 62 Stat. 6279, 14 U.N.T.S. 185 (July 22, 1946).

166. Many note that this trend of making all of human well-being a health issue is something of “health imperialism”—whereby health policy is extended to deal with all of human well-being.

concepts of health ranging from narrow anatomical to broader quality of life views.

One model of health falls between these extremes, offering the following definition:

1. The state of the organism when it functions optimally without evidence of disease or abnormality. 2. A state of dynamic balance in which an individual's or a group's capacity to cope with all the circumstance 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.¹⁶⁷

This model defines health and disease by building, though not solely, on medical research, education, knowledge, and practice. In this view, health is a multidimensional construct that includes psychosocial as well as physical aspects.

This model identifies, diagnoses, and prognosticates over the process of change along a continuum between healthy and not healthy. It rests on the understanding that humans are biological organisms living in social environments. It thus concerns both physical and mental states and recognizes that humans interact as social organisms. For example, one field, occupational therapy, helps people return to work, school, and other social environments. The model typically does not reach beyond these fields to promote social functioning, such as relationship development, except during treatment for mental illness. But neither does it completely reject the social etiology of health and disease. The third part of the definition above includes the ability to perform valued family, work, and community roles. It differs from the narrow biomedical model of health, which stands primarily on anatomical and biological facts rather than social and moral understanding. A narrow bio-medical model of disease also fails to specifically address the adaptation and balance required on the part of *society* to enable individuals to flourish. For example, the need for societal norms that value and support the human dignity of all persons, regardless of functioning level and that entail a broad and inclusive view of normality, which respects all human life.

This model, however, is less relative to particular social norms and values than other concepts of health and disease.¹⁶⁸ It also demonstrates

167. STEDMAN'S MED. DICTIONARY 789-790 (27th ed. 2000).

168. On this see, for example, Engelhardt, *supra* note 163, who argues that the concept of disease can be normative—subject and relative to social norms and values. Christopher Boorse has also defended a mechanistic or biological view of health and disease, arguing that disease is a biological malfunction—a deviation from the biological norm of normal function. See Christopher Boorse, *On the Distinction Between Disease and Illness*, 5 PHIL. & PUB. AFF. 49 (1975).

that a more expansive model of health contains many core elements of other models, although it does not go so far as to include everything that might constitute quality of life.

This model reflects an incompletely theorized agreement on the importance of core dimensions of health. Its definition brings together these overlapping elements toward greater standardization in conceptualizing health. It also fits well with the capability approach, even including the concept of freedom from the risk of disease or untimely death. Most importantly, it includes both *potential* health and *actual* health as part of the definition of individuals' practical opportunities for optimal health—a duality embedded in an account of capability and health. It has promise to serve as a middle-ground or shared standard for health assessment.

Thus, an expanded model of health, which does not go all the way to include everything that is quality of life, can define the central features of human health at a *practical* (if not an epistemological) level.¹⁶⁹ These central features represent universally shared elements of health. I propose using this model of health when applying the capability view to public policy and a right to health because it is a clear, grounded, and agreed-upon view. And like the capability approach, it includes two levels of analysis: *potential* and *actual*, health capabilities constitute the abilities of individuals to achieve certain health functions. The overall set of health capabilities represents a person's overall freedom to achieve health functionings.¹⁷⁰ It also has a dynamic and synergistic quality, recognizing the changing interaction of the individual with the broader social environment and the individual's ability to respond positively to changing socio-economic circumstances in order to achieve one's potential in health through realization of health goals and the meeting of health needs. As such, it is useful in determining how we might go about assessing health policies and interventions.

An expanded model of health, which forms the foundation for prevention and treatment, provides a workable distinction between health-related needs and the goods and services that address those needs.¹⁷¹ As

169. In addition to the advantage of this account in providing a consensual view, by grounding the definition of health in the medical sciences, the components of the account are comparable, and in a sense commensurable, across humanity, relating to Sen's "global" point of view. It thus allows—to a certain extent—intra-and inter-personal comparability—allowing for measures and indicators of health and health capabilities to be used for policy analysis.

170. See Ruger, *supra* note 131, for a conceptual model and index of health capability.

171. Central health capabilities, as discussed in Ruger, *Aristotelian Justice*, *supra* note 8, at 108–112, are embodied in the following set of key health-related needs for: (1) the need for individual health-care goods and services (prevention, diagnosis, treatment, rehabilitation) that promote the capability for a level of physical and mental functioning and lifespan that is maximal and achievable; (2) the need for public health goods and services and social support services; and (3) the need for adequate nutrition and sanitary, safe living and working environments.

the scope of resource distribution broadens, it may be necessary to harmonize conflicting views at different levels, but these steps should occur incrementally.

B. Duties and Obligations in Domestic and International Policy and Law: Ethical Commitments and Public Moral Norms

The primary means for actualizing a right to health are both legal and non-legal instruments. This Article proposes an *ethical commitment* to the right to health. This commitment sees the right to health as the basis and inspiration for new and specific legislation. It also sees it as an ethical claim, in this case on all individuals, especially the wealthier, to redistribute some of their resources to help meet the health needs of others (e.g., those who are unable to afford care). Under a capability and health account, this obligation refers to an interest in the significant capabilities or freedoms of others as operationalized in terms of health needs, functionings and capabilities, not their preferences, desires, or utilities.

Because the fulfillment of a right to health requires social organization in the form of a redistribution of resources, and related legislation and regulation, this obligation requires an ethical commitment on the part of all individuals, those most fortunate and those in need, to the end goal of providing the capability to be healthy to all. Without this ethical commitment, redistributing resources from the wealthy to those less fortunate and from the well to the sick, will not be possible, because the effort to do so must be *voluntary*, not coercive. As such, individuals must internalize the *public moral norm* that health is worthy of social recognition, investment and regulation to the point of successfully operationalizing such a right. The ethical significance of the right to health provides strong grounding for individual and state action to respect, protect, and fulfill the right to health through institutional change.

From an ethical point of view, as Sen notes, the obligation of individuals—and by extension the duty of states—requires them to address threats to individuals' human rights.¹⁷² Sen applies Immanuel Kant's category of duties known as "imperfect obligations" to human rights analysis as the basis for this obligation. In this analysis, human rights yield both perfect and imperfect obligations.¹⁷³ Determining the extent and scope of such claims—for example, in applying this viewpoint to health—our perfect and imperfect obligations to respect, protect, and fulfill individuals' right to health requires a framework of *normative* reasoning. Such reasoning involves dialogue about the ethical dimensions of health and health policy and the need for collective action through

172. SEN, *supra* note 26, at 317-318.

173. *Id.* at 340-342.

public financing, regulation, and in some cases, provision of services. It also requires regulation and oversight of the health system and it calls for establishing social norms of inclusive diversity to create the conditions in which each individual may achieve her potential in health. In short, such realization is more likely to occur when individuals within a given society, take ownership of the public moral norm as a guiding principle for their individual and collective efforts, as evidenced by their *domestic* social, political, and economic activity. Blunt legal instruments cannot fully embody this framework. Legal instruments will ultimately require interpretation in any case. In the sections that follow I argue for a particular type of normative reasoning about justice and health policy, providing a framework for respecting, protecting and fulfilling the right to health in a society. I defer the discussion of legal instruments and the role of the courts vis-à-vis legislation and policy to other works.

C. Framing a Right to Health: Equality as the Standard

1. Inequality and the Right to Health: Shortfall from the Highest Attainable Standard of Health

This Article has reasoned that health capabilities should be a central goal of health policy and that a subset of core health capabilities should receive priority in assessing the equity and efficiency of health policies. It has argued that a subset of functionings and associated health needs can serve both as an indicator and as a causal link to a capability set. We now must identify a suitable standard of equality to judge public policies affecting health and to evaluate a right to health.

2. Attainment and Shortfall Equality

Equality can be classified as “attainment equality” or “shortfall equality.” The distinction is important when assessing health capabilities.¹⁷⁴ Attainment equality compares individuals according to *absolute levels of achievement*, whereas shortfall equality compares *shortfalls of actual achievement from the optimal average* (such as typical longevity or physical performance). There are different reasons¹⁷⁵ for taking each approach when assessing equality, and each measure is informative. Because attainment equality compares absolute achievement levels and disregards the maximal potential of individuals or groups, it

174. For an illuminating discussion of this distinction see SEN, *supra* note 43; and Anand & Sen, *supra* note 122. See also generally WORLD BANK, *POVERTY*, *supra* note 122.

175. On this see SEN, *supra* note 43, at 89-91. As Sen notes, shortfalls have been used in the welfare-economic literature for many decades, by scholars such as Ramsey, Atkinson, Dalton, and Musgrave, among others.

limits society's obligation to address potential achievement. Thus, it has the disadvantage of a "'levelling-down' of all to the condition of the lowest achiever"¹⁷⁶ so that the attainment goal will be a "'low level equality for all'"¹⁷⁷ and many individuals will not realize their full potential.¹⁷⁸ Alternatively, the concept of shortfall equality can assess health capabilities, especially when equalizing achievements for different people is difficult. This is because human diversity can prevent some people from achieving maximal health and thus undermine the goal of equalizing maximal health levels potentially achievable by all. This approach might be particularly relevant for assessing the health capabilities of people with disabilities because it accounts for differences in the maximal potential for health functioning without "leveling down" achievement goals of the entire group. It is also consistent with Aristotle's conception that an arrangement is best if it "brings people as close to good functioning as their natural circumstances permit."¹⁷⁹ Moreover, shortfall can be measured in either absolute or proportional terms, allowing proportional weighting for people with severe disabilities or at the international level weighting for countries with significant health deprivations.¹⁸⁰ Shortfall equality is also more consistent with the emphases on health as "optimal functioning," "a group's capacity to cope with all the circumstance of living . . . at an optimum level" and with "freedom from risk of disease."¹⁸¹ Shortfall equality offers a promising way to evaluate health policies and a right to health by whether they promote "equal use of the respective potentials."¹⁸² This approach can also justify having good health as an end goal of public and health policy if we acknowledge that it is impossible to guarantee good health or equal health¹⁸³ to everyone.

At the societal level, shortfall equality can be used to assess quantitatively how much a given society has realized its health potential

176. SEN, *supra* note 43, at 93.

177. *Id.*, at 92.

178. Much of the current work in health and health care disparities takes the form of intergroup differences in health attainment or health care access. As such, health and health care indicators are stratified by income, education, social class, race, ethnicity, geographic location and more. For more on this see, Jennifer Prah Ruger, *Measuring Disparities in Health Care*, 332 BRIT. MED. J. (forthcoming 2006). For a graphical illustration demonstrating the differences in policy implications resulting from an intergroup attainment versus a shortfall inequality perspective, see Jennifer Prah Ruger, *Ethics and Governance of Global Health Inequalities*, 60 J. EPIDEMIOLOGY & COMMUNITY HEALTH (forthcoming 2006) For an empirical cross-national study of global health inequalities from a shortfall perspective, see Jennifer Prah Ruger and Hak-Ju Kim, *Global Health Inequalities: An International Comparison*, 60 J. EPIDEMIOLOGY & COMMUNITY HEALTH (forthcoming 2006).

179. Nussbaum, *Political Distribution*, *supra* note 63, at 155.

180. See U. N. DEV. PROGRAMME, HUM. DEV. REP. (2003)

181. STEDMAN'S MED. DICTIONARY, *supra* note 167, at 789-790.

182. Sen, *supra* note 43, at 91.

183. Indeed this concern has been noted as a reason for *not* making health a primary good in social evaluation. See DANIELS, *supra* note 9, at 7-8; RAWLS, *supra* note 41, at 62.

and how much remains unrealized, because it compares the actual achievement of a given public policy or health system (or limitations thereof) with the possible maximum. The typical unit of analysis for comparing countries is the nation-state, though it can also compare groups within countries. This analysis focuses less on the accomplishments of health systems and health policies. Rather, it estimates what should be possible and how to prioritize resources in order to reduce the gap between achievements and potential. For example, a high prevalence of preventable death and disease (e.g., high rates of AIDS, TB, Malaria) would clearly imply that a group was falling short of its health potential and that public policies and the health sector were falling short of their obligations. Ultimately, the responsibility for rectifying such injustices lies with the government and its policies.

At the societal level, proportional reduction in shortfall can measure inequality. The United Nations used this approach to compare life expectancies in different countries.¹⁸⁴ When the target average life expectancy is 81 years,¹⁸⁵ for example, the shortfall is reduced by a larger proportion when a population's average life expectancy changes from 60 to 70 years of life expectancy (a 10-year reduction in a 21-year shortfall) than when it moves from 30 to 40 years (a 10 year reduction in a 51-year shortfall). Therefore, the proportional reductions in the two shortfalls would be 0.48 (10/21) and 0.20 (10/51), respectively. Such calculations assume that both populations are capable of reaching the target average life expectancy of 81 years, which is the highest attained by any nation-state, in this case Japan. Using this standard, Sierra Leone has a shortfall of 46 years, whereas Uruguay's shortfall is 7 years. When the proportion of shortfall reduced is used as an indicator of improvement in life expectancy, it provides a measure of progress toward boosting health capabilities to certain levels. In the developing world, especially, the shortfall must diminish considerably to reach the target of 81 years.¹⁸⁶ Thus, many countries are falling far short of their potential to maintain and improve the health of their populations or of different subgroups.

184. See, e.g., WORLD BANK, CHANGING WORLD, *supra* note 122; WORLD BANK, POVERTY, *supra* note 122.

185. Measurements of maximal average achievement would employ some reference status. For example, to measure shortfall equality in longevity one might assess premature death as death that occurs prior to the age to which a person might be expected to live, which would be the average life expectancy at birth of the world's longest surviving population (e.g. Japan with an average life expectancy of eighty-one years (1995-2000)). See Sudhir Anand & Amartya Sen, *Gender Inequality in Human Development* (U.N. Human Development Reports, Occasional Paper No. 19, 1995).

186. An earlier United Nations Development Programme (UNDP) Report 2001 used a maximum value of eighty-five years as a goal post for life expectancy at birth in calculating its annual Human Development Index (HDI). The life expectancy index measures the relative achievement of a country in life expectancy at birth—calculated as the ratio of the actual value minus the minimum value (twenty-five) to the maximum value (eighty-five) minus the minimum value (twenty-five). See U. N. DEV. PROGRAMME, HUM. DEV. REP. 13 (2001).

At the level of the individual, there also is a case for assessing inequality in terms of shortfall, or even proportional shortfall, to permit functional comparisons between those with and without chronic illnesses or disability. This application must proceed with caution, however. Sen argues that “in the case of serious disabilities, attainment equality may be hard to achieve, and it may be particularly tempting to opt for shortfall.”¹⁸⁷ Later, he warns against applying the concept of shortfall equality too strictly. He notes that while

a disabled person, in any way, be given the freedom to enjoy the *same* level of functioning in question . . . there is nevertheless a good case—based on fairness—for trying to maximize his . . . functioning ability, rather than settling for the same shortfall (absolute or proportionate) as others have from their—much higher—maximal functioning¹⁸⁸

Thus the goal in this case at the individual level is again assessing the maximal potential functioning and reducing the gap or shortfall between realized and potential functioning for the individual.

From this perspective, in implementing a right to health, we should be concerned with reducing inequalities in health capabilities among individuals and groups. Such concern accords with Aristotle’s conception of political distribution, which requires the state to distribute the conditions allowing each individual to achieve the highest possible level¹⁸⁹ of health functionings in order to choose and live a good life. This task aims to optimize every individual’s functioning.¹⁹⁰ Justice in health policy requires rules that allow a society to maintain and improve health capabilities in accordance with these principles.¹⁹¹

187. SEN, *supra* note 43, at 75.

188. *Id.* at 91.

189. This conception, although similar to Rawls’s maximin principle, is slightly different. With reference to severe conditions (those with very low maximum possible achievements), for example, there is still the case from a shortfall point of view of reducing the gap between potential functioning and realized functioning. Rawls’s application of the maximin principle to primary goods, meanwhile, aims to make the worst off as well off as possible. But Rawls does not provide guidance on the limits of justice in the face of intractable situations.

190. This conception of justice and health is counter to utilitarian conceptions in which it would be plausible that a person with a higher utility—greater preference—would have a greater claim than someone with a lower utility. For a criticism of this aspect of utilitarianism, see Nussbaum on the utilitarian neglect of the separateness of persons—“the ethical salience of the boundaries between persons.” Nussbaum, *supra* note 42, at 231.

191. Each society will have a slightly different set of guidelines for the distribution of resources in accordance with the overarching goal of reducing shortfall inequalities in health capabilities of its population. Each society will have a different ability to pay—a different total budget and different relative costs of necessary services (e.g. a poor society may have less to spend on services, but it also may need less to spend due to the lower costs of those services)—and each society will have a different number of people who require services for maintaining and improving health capabilities.

D. Efficiency Under Scarcity and the Right to Health

Another key concept on the capability view is that efficiency concerns should temper the goals of equality. The efficiency described here requires “the wasteless, productive promotion of objectives (no matter what these objectives are.)”¹⁹² While consistent with welfare economics in its focus on efficiency, the capability view differs by *allowing efficiency principles to be applied to equity goals*. Thus, the nation-state should strive for reducing shortfall inequality in health capabilities as efficiently as possible, using as few resources as possible. When choosing between two services that promote the same level of health capabilities,¹⁹³ for example, it should select the less costly. The capability view thus endorses the dual social obligations of equality and efficiency in health resource allocation. Because many of the necessary conditions for individuals to lead healthy lives are beyond the scope of the market to provide, state intervention and the analysis of state regulation and programs are necessary.

As I argue elsewhere, attempts to achieve optimal levels of health and reduce inequalities in individuals’ abilities to be healthy with the fewest resources will require a joint clinical and economic solution.¹⁹⁴ The general approach advocates weighing risks, benefits, and costs on at least two levels. At the societal level, citizens, physicians, and public health experts delineate a package of goods and services to which all individuals are entitled. Cost-minimization and cost-effectiveness analyses¹⁹⁵ provide economic input in the decision-making process.¹⁹⁶ Its stepwise approach first addresses equity, using clinical input to promote equality in individuals’ ability to be healthy; then it addresses efficiency by using cost-minimization analysis and, in specific cases, cost-effectiveness analysis. This process differs from other efforts¹⁹⁷ to address the efficiency-equity trade-off¹⁹⁸ in health policy because it is iterative and

192. SEN, *supra* note 43, at 140.

193. Effectiveness here is measured in terms of the indicators of health capabilities listed *supra* note 130.

194. See Ruger, *supra* note 31, at Section IV.C.10, for joint economic and clinical solutions and recommendations on incorporating efficiency analyses.

195. Results from cost-effectiveness analysis can be useful inputs to decision-making to outline the trade-offs between costs and effectiveness. See generally, Karen M. Kuntz et al., *Expert Panel Versus Decision-Analysis Recommendations for Post-discharge Coronary Angiography After Myocardial Infarction*, 282 J. AM. MED. ASS’N 2246 (1999).

196. Ruger, *supra* note 31, at Section IV.C.10.

197. Paul T. Menzel, for example, argues for securing individual consent to different rationing options. See MENZEL, *supra* note 70. Eric Rakowski supports employing hypothetical choice constructs such as the “veil of ignorance” in making resource allocation decisions, arguing that individuals would choose random selection, with a caveat for age and prognosis. See ERIC RAKOWSKI, EQUAL JUSTICE (1991); Eric Rakowski, *Taking and Saving Lives*, 93 COLUM. L. REV. 1063 (1993).

198. On the ethical implications of Quality-Adjusted-Life-Years (QALYs), see Paul T. Menzel, *QALYs: Maximization, Distribution and Consent. A Response to Alan Williams*, 3 HEALTH CARE ANALYSIS 226 (1995); and Alan Williams, *QALYs and Ethics: A Health Economist’s Perspective*, 43 SOC. SCI. & MED. 1795 (1996).

uses a variety of methodologies to address the competing social obligations of equality and efficiency.¹⁹⁹

At the individual level, individuals decide whether to choose a particular public health or clinical intervention on the basis of full information about its risks and benefits. At the individual level, if individual agency is complete, input from physicians and public health experts can provide objective information for effective choice. Some efficiency gains might also result from expanding shared decision-making, which can decrease costs when individuals decide not to pursue a given treatment after weighing the risks and benefits.²⁰⁰

*E. The Right to Health and Social Determinants*²⁰¹

A central goal of a capability and health account of the right to health is to reduce inequalities in individuals' ability to achieve health-related functionings. Although many factors influence health, health policy (health care and public health) continues to be one of its most influential determinants. Therefore, public policy that attempts to address a particular population's and individual's shortfall from optimal health should rest on information about factors contributing to that shortfall. The analysis should include the scope, interaction, and policy influence of different policy domains.

A number of policy domains influence health. We are far from understanding the precise societal mechanisms that influence health or how to weight different social objectives. Even in light of existing information on health's social determinants, it is therefore unwise to attempt to improve health with broad non-health policies, such as completely flattening socioeconomic inequalities, as prescribed by some.²⁰² Such prescriptions cloud rather than clarify the means and ends of health policy and our ability to evaluate the impact of public policy on health. And as Frances Kamm notes, it would be necessary to compare

199. Empirical studies are increasingly finding that individuals tend to emphasize value of life rather than level of health benefit after treatment (e.g. capacity to benefit) in their ethical preferences. People are reluctant to deny treatment to individuals based on their benefit maximization. Eric Nord and others propose an approach called the "cost-value analysis" in which they employ equity weights to incorporate concerns for health severity in QALY calculations. See Eric Nord, *The Relevance of Health State After Treatment in Prioritizing Between Different Patients*, 19 J. MED. ETHICS 37 (1993); Eric Nord, *The Trade-Off Between Severity of Illness and Treatment Effect in Cost-Value Analysis of Health Care*, 24 HEALTH POL'Y 227 (1993); Eric Nord et al., *Incorporating Societal Concerns for Fairness in Numerical Valuations of Health Programmes*, 8 HEALTH ECON. 25 (1999).

200. For example, use of appropriateness guidelines could reduce cost-ineffective care. A study that compared appropriateness ratings of coronary angiography after myocardial infarction (MI) made by an expert panel with cost-effectiveness ratings predicted by a decision-analytical model found that the clinical scenarios considered appropriate by the expert panel were more cost-effective (average of \$27,000 per QALY gained) than those deemed inappropriate by the panel (average of \$54,000 per QALY gained). See Karen Kuntz et al., *supra* note 195, at 2246.

201. This section relies heavily on Ruger, *supra* note 56.

202. Norman Daniels, *Justice, Health, and Healthcare*, 1 AM. J. BIOETHICS 2 (2001).

health gains from economic growth associated with social inequality with health gains from complete social equality²⁰³ in order to fully understand the net effects of these alternatives. Ezekiel Emanuel has listed a series of political problems associated with the strategy of eliminating all socioeconomic inequalities.²⁰⁴ For evaluations that include the social determinants of health, a complete comparison of a number of different objectives in addition to health is in order. Such evaluations are beyond the scope of the current work. General Comment 14 stipulates, however, that implementation of a right to health requires identifying appropriate right to health indicators and benchmarks. In doing so, important distinctions are required. As I argue elsewhere,²⁰⁵ a distinction between *supplementing* and *replacing* domain-specific criteria in policy assessment is essential, as is a need to keep the domain of “health policy” distinct from other policy domains. Ultimately an integrated approach to public policy is required.²⁰⁶

CONCLUSION

This Article has provided a philosophical justification for a right to health. It has developed a theoretical framework that has built on and integrated Aristotle’s political theory, the capability approach, and a social choice paradigm known as incompletely theorized agreements. This approach—a capability and health account—integrates elements of alternative conceptions to address unresolved disagreement about the right to health and to produce workable solutions that move beyond “discordant positions, irresolution, and an exhausted uncertainty” that “seem the only conclusive products of three decades of discussion on medical ethics.”²⁰⁷ Consequently, it favors a view of the right to health and justice in public policy affecting health that is “mutually acceptable to people whose preferences diverge.”²⁰⁸

To promote the good life, a capability and health account values longevity and freedom from disease. It emphasizes prevention and

203. Frances M. Kamm, *Health and Equality of Opportunity*, 1 AM. J. BIOETHICS 17 (2001).

204. Ezekiel J. Emanuel, *Political Problems*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 59. For additional useful critiques of this approach see Marcia Angell, *Pockets of Poverty*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 42; Sudhir Anand & Fabienne Peter, *Equal Opportunity*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 48; Barbara Starfield, *Primary Care*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 67; Emmanuela Gakidou et al., *A Health Agenda*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 71; Ted Marmor, *Political Options*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 53; and Michael Marmor, *Do Inequalities Matter?*, in DANIELS ET AL., *BAD FOR OUR HEALTH*, *supra* note 51, at 37.

205. Ruger, *supra* note 56.

206. See also Jennifer Prah Ruger, *Global Tobacco Control: An Integrated Approach to Global Health Policy*, 48 DEVELOPMENT 65 (2005).

207. EMANUEL, *supra* note 38, at 6.

208. Scanlon, *supra* note 150, at 668.

treatment, favoring those most deprived in health and at risk of health deprivation. It also emphasizes individual agency and supports efforts to improve health to equip individuals with the mental and physical ability required for agency. Moreover, it values cost-minimization analysis and the use of cost-effectiveness analysis (CEA) in specific situations and stresses shared health decision-making at the societal and individual levels. It emphasizes the importance of viewing the right to health as an ethical demand for equity in health and the need for the internalization of public moral norms to progressively realize this right. Moreover, it promotes a more nuanced tact on the social determinants of health and an integrated and multifaceted approach to enabling "human flourishing." Together these principles offer the beginnings of a theory of the right to health.