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# DEFINING "HEALTH": THREE VISIONS AND THEIR RAMIFICATIONS

David S. Bloch\*  
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*"The arguments that have been offered ... leave me unsatisfied, however, in the sense that I still want to hear a definition of them both, and to be told what the effect is of the occurrence of each of them ..."*

— Plato, *The Republic* 358b.<sup>1</sup>

## INTRODUCTION

On August 11, 1995, the Food and Drug Administration (FDA) announced an ambitious effort to regulate cigarettes.<sup>2</sup> Its plan, backed by the Clinton Administration, would classify nicotine as a drug, define cigarettes as drug delivery device, and bring cigarettes into FDA's regulatory purview.<sup>3</sup> The

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<sup>1</sup>PLATO, REPUBLIC 45 (Robin Waterford trans., Barnes & Noble Books 1993)

<sup>2</sup>*Cigarette Regulation is Formally Proposed; Industry Sucs to Halt It*, WALL ST. J., Aug. 11, 1995, at A1; Mark Sandalow, *Clinton Orders Rules to Snuff Teen Smoking*, S. F. CHRON., Aug. 11, 1995, at A1.

<sup>3</sup>Sandalow, *supra* note 2, at A1; Michael K. Frisby & Hilary Stout, *Clinton to Back: Cigarette Curbs*, WALL ST. J., Aug. 3, 1995, at A3 (the Administration has decided to "back the Food and Drug Administration's quest to gain regulatory authority over cigarettes. Such a decision represents a broad interpretation of the FDA's authority. The agency argues that it should be able to regulate cigarettes because they contain the drug nicotine"). It should be noted that the present regulatory proposals are intended only to prevent adolescent smoking. However, the redefinition of cigarettes as drug delivery devices will put cigarettes as a class into the reach of the

Administration, prompted by former FDA Commissioner Dr. David Kessler, has made no secret of its intention to use this mechanism to sharply restrict cigarette advertising and sales.<sup>4</sup>

It is not seriously disputed that cigarette smoking is directly and causally associated with a variety of health problems. Though tobacco smoke is neither a necessary nor a sufficient cause of cancer, because lung cancers develop in non-smokers and some smokers do not develop lung cancer, cigarette use is clearly associated with a massively increased risk of disease.<sup>5</sup> Regulation of cigarette use, however, raises thorny problems regarding personal liberty.<sup>6</sup> Ultimately, the issue of smoking regulation centers around two related issues: how to characterize "health," and who is responsible for maintaining it.

When we refer to "health," we do not mean "health care," but rather health itself, or a person's physical well-being.<sup>7</sup> Many choices, including organ donation, choice of diet, and money spent on risky athletic pursuits, impact a person's health. Part of the costs and benefits of certain choices is a change in health status, and surely some actions are taken because of their influence on the actor's health. It is thus reasonable to conceptualize

Food, Drug and Cosmetic Act, 21 U.S.C. §§ 340 *et seq.* The FDA has broad discretion to determine what substances fall within its jurisdiction, though the matter is by no means legally settled. See Milo Geyelin, *Does FDA's Power Extend to Cigarettes?* WALL ST. J., Aug. 4, 1995, at B7.

<sup>4</sup>Frisby & Stout, *supra* note 3, at A3; *Cigarette Regulation is Formally Proposed; Industry Sues to Halt It*, WALL ST. J., Aug. 11, 1995, at A1; Maggie Mahar, *Blowing Smoke: Despite Heated Attack by Tobacco Industry, FDA is Likely to Regulate Cigarette Sales*, BARRON'S, Jan. 8, 1996, at 12.

<sup>5</sup>DAVID E. LILLIENFIELD & PAUL D. STOLLEY, FOUNDATIONS OF EPIDEMIOLOGY 9-11 (3d ed. 1994).

<sup>6</sup>"By calling behavior a disease, [Kessler] obscures the fact that, whenever they start, smokers choose to continue smoking *every day*. They may be ambivalent about it, but they have implicitly decided that the costs of quitting exceed the benefits." Jacob Sullum, *Smoking Wars*, NATIONAL REVIEW, July 29, 1996, at 40 (*italics original*).

<sup>7</sup>Webster's contains two pertinent definitions of "health":

1. "physical and mental well-being; soundness; freedom from defect, pain, or disease; normality of mental and physical functions."
2. "condition of body or mind, as, good or bad *health*."

WEBSTER'S NEW UNIVERSAL UNABRIDGED DICTIONARY 836 (deluxe 2d ed. 1983). Litman observes that "[t]he notion of health is a popular one: The public, for good or ill, remains convinced of the efficacy of medicine in promoting and maintaining it and believes that future medical advances guarantee less sickness and longer life." Theodor J. Litman, *Government and Health: The Political Aspects of Health Care — A Sociopolitical Overview*, in HEALTH POLITICS AND POLICY 3, 30 (Theodor J. Litman & Leonard S. Robbins eds., 2d ed. 1991).

a person's health as a distinct object or entity, and to attempt to ascertain its characteristics as such.<sup>8</sup> Though health care is a controversial topic in legal and social theory, "health" is usually an unexamined variable. This omission is a mistake, because discussions of health care policy are incomplete, if not misleading, without careful consideration of the characteristics of health itself.

Before discussing any program aimed at improving, protecting, or even harming health, it is necessary to define the concept of "health" with reasonable precision. To the extent that theorists have considered the formal definition of health, three broad definitions can be discerned. First, some commentators view health as an inborn attribute, a state of being or, at most, an inalienable characteristic. In economic parlance, health is a non-good. A second group of theorists views health as a merit good. Under this conception, health implicates such important societal goals (or creates such substantial externalities), that good health becomes a social good, benefiting both the holder of health and his community. These social benefits are considered so central that community resources can justifiably be dedicated to individual health maintenance. For moral or social reasons, however, health cannot be the subject of market transactions and, thus, is "nonsalable" or "market-inalienable."<sup>9</sup> A third group of theorists views health as purely an economic good fundamentally indistinguishable from any other purchasable item. This article develops these three visions of health, assesses their viability, and discusses the implications of each for government and society.

### CONCEPTIONS OF HEALTH

As noted, there are three ways to conceptualize health:

- (1) as a non-economic good or a non-good;
- (2) as a special "merit" economic good, subject to unique considerations and constraints; and
- (3) as an ordinary economic good.

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<sup>8</sup>We should also add a word on terminology. This article uses economic jargon, even when discussing concepts that expressly reject the economic frame of mind and the language that accompanies it. We use this language because it is the simplest, most direct way of communicating what we are trying to communicate.

<sup>9</sup>Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1850 (1987).

### **Health as a Non-Good -- The Right to Good Health**

Health can be viewed as an attribute or trait of a fundamentally non-economic nature. In effect, this means health cannot be adequately valued by the marketplace. The mere fact that one can affect his or her health status by conscious effort does not mean health is an economic good. Health is either critically undervalued, or of transcendent value. There simply cannot be a fair market exchange for one's health; because any trade, despite the mutual willingness of the parties, is wrong. The moral case underlying this view is that economic circumstances should never force a person to degrade his life.<sup>10</sup>

#### **Rawlsian Justifications**

John Rawls' theory of justice underlies this particular view of health.<sup>11</sup> Rawls proposes two basic principles of justice in society, which he bases on a theoretical social contract that all people would enter if each operated behind a "veil of ignorance." That is to say, not knowing if one will be strongest or weakest, brightest or dimmest, Rawls argues each person will agree with the following two maxims:

***First Principle:***

Each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all.

***Second Principle:***

Social and economic inequalities are to be arranged so that they are both:

- (a) to the greatest benefit of the least advantaged ...; and

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<sup>10</sup>"Something might be prohibited in its market form because it both creates and exposes wealth- and class-based contingencies for obtaining things that are critical to life itself -- for example, health care -- and thus undermines a commitment to the sanctity of life." Radin, *supra* note 9, at 1912 (footnotes omitted). See also Roger M. Battistella, James W. Begun & Robert J. Buchanan, *The Political Economy of Health Services: A Review of Major Ideological Influences*, in HEALTH POLITICS AND POLICY 66, 68 (Theodor J. Litman & Leonard S. Robbins eds., 2d ed. 1991).

<sup>11</sup>See, e.g., Wendy K. Mariner, *Access to Health Care and Equal Protection of the Law: The Need for a New Heightened Scrutiny*, 12 AM. J. L. & MED. 345 (1986).

- (b) attached to offices and positions open to all under conditions of fair equality of opportunity.<sup>12</sup>

Rawlsian fairness dictates that inborn characteristics or diseases should not be allowed to restrict an individual's opportunities.<sup>13</sup> If health is an exogenous variable, subject to change at any time for nearly any reason and largely beyond an individual's control, then basic considerations of fairness require a system of laws that protects individuals from possible health-related bad fortune.

Smoking is, of course, a conscious act. But, Rawlsian justice seeks to protect liberty to the maximum extent feasible. It is not entirely clear how a Rawlsian society would deal with deliberately risky behaviors, particularly when the consequences of those behaviors are borne to some extent by other citizens. Even with regard to diseases associated with risky activities, the limitation of benefits is unjust in a Rawlsian society:

Medical services necessary for the treatment of heart disease, liver disease and AIDS are clearly intended to prevent death and alleviate serious impediments to normal human functioning... . If such services were limited ... to avoid creating incentives for behaviors that could promote such diseases, the fit between the classification criteria and the objective is obviously weak.\* [\*[D]etermining eligibility for benefits on the basis of disease alone is not likely to serve the purpose of discouraging disfavored behavior to any appreciable degree. Despite epidemiological evidence that a substantial proportion of lung cancer is caused by smoking, for example, a simplifying assumption that all smokers' lung cancers are attributable to their smoking behavior would undoubtedly cast too wide a net.]<sup>14</sup>

A smoker in a Rawlsian society is thus entitled to a subsidy for any illness he may eventually develop, because adverse health is still largely a "lottery." Viewing health as a lottery leads logically, in a Rawlsian world, to laws guaranteeing medical care. Justifications for viewing health as a non-good, based upon Rawls' theory of justice, result in proposals to conceptualize health as a positive right, guaranteed in and protected by the

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<sup>12</sup>JOHN RAWLS, A THEORY OF JUSTICE 302 (1971).

<sup>13</sup>Mariner, *supra* note 11, at 373.

<sup>14</sup>*Id.* at 376 (bracketed section is footnote 132 in the original).

Constitution of the United States.<sup>15</sup> This concept has driven a welter of proposals and policies, culminating in the creation of Medicare in 1965.<sup>16</sup> Yet the United States has proven uniquely resistant to single-payer medicine. It is fairly clear that the health care system implied by this view of health is, for the present, politically infeasible.

### Non-Rawlsian Justifications

If we determine that Americans are unwilling to accept the program implied by the Rawls' view of health, the question remains whether a non-Rawlsian theory of health as a non-good can promote effective public policies. Rawls aside, the concept of health as a non-good rests on three propositions. First, health is a positive right; and, therefore, whatever the instrumental justification, people have a right to be healthy. Second, positive rights cannot be alienated, meaning a person cannot sell himself into slavery and cannot legitimately act to sabotage his own health. Third, government is a guarantor of positive rights, and therefore is obligated to protect and promote the health of its citizens.

Distilled in this way, the notion of health as a non-good is flawed. The problem is twofold. First, it is impossible to fully delimit the area covered by a positive right to health. As such, government has broad discretion to enact protections; there is no obvious limit to the actions a well-meaning legislature could take to protect and enhance the health of its citizens. In effect, this becomes a grant not unlike that of the Commerce Clause, an almost unlimited police power, permitting a wide range of significant regulatory activity with only casual relation to health as we understand it. "Health" could easily become a catch-all justification for broad governmental regulation of areas once left to the States and the people.

In the case of criminal homicide, for instance, "the duo of the murderer and the victim could be considered the host, the weapon is considered the disease agent, and the circumstances surrounding the homicide fall into the environment category ... . Most public health

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<sup>15</sup>*See id.*

<sup>16</sup>"[R]eformers at the turn of the century unsuccessfully sought to humanize many of the demeaning aspects of charity and welfare medicine ... they endeavored to establish the principle that health services ought to be provided as a right on the basis of medical need regardless of ability to pay ... . After nearly 50 years of ceaseless but unfulfilled strivings, these efforts were rewarded partially with the passage of Medicare in 1965." Battistella, Begun & Buchanan, *supra* note 10, at 67-68.

officials say [an] environmental shift must be made in the area of homicide, and that translates to control of handguns."<sup>17</sup> The logic is seductive, but the result is illiberal because it fails to even consider the twin matters of individual autonomy and individual responsibility, and allows the federal government to derogate the general police power held exclusively by the States.<sup>18</sup>

Second, if health is a positive right, the logical response to health threats is prohibition. Cigarettes should be banned altogether, along with other demonstrably harmful substances (e.g., alcohol). Prohibition, however, raises problems of its own. If the government earmarks a set level of resources for enforcement, it must also accept that the law will be circumvented to some degree. This was the strategy of the alcohol Prohibition of the 1920s.<sup>19</sup> The result was the creation of vast criminal empires, the effects of which can be felt today from the docks of New York City to the corridors of power in Washington D.C.<sup>20</sup> In the alternative, the government may choose to devote sufficient resources to absolutely eradicate the trade in both legal and illegal markets. However, to control illegal production, massive new social controls are necessary. In effect, the alternative would create a benign, health-conscious dictatorship.

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<sup>17</sup>Nikki Meredith, *The Murder Epidemic*, SCIENCE, Dec. 1984, at 42, 43-44, 46.

<sup>18</sup>JEROME A. BARRON ET AL., CONSTITUTIONAL LAW: PRINCIPLES AND POLICY 85 (4th ed. 1992). It should be noted that the modern Commerce Clause has provided the federal government with powers that approach that of a general police power. It is clear that the Founders did not intend such a power, since four resolutions intended to confer it were defeated during the Constitutional Convention in Philadelphia. *Id.*

<sup>19</sup>President Clinton has stated that he has "no intention of banning cigarettes, [because] such a step would be no more successful than Prohibition was at eliminating alcohol in the 1920s." Sandalow, *supra* note 2, at A13.

<sup>20</sup>That Prohibition is largely responsible for the rise of American Mafia kingpins is conventional wisdom. See, e.g., Robert K. Woetzel, *An Overview of Organized Crime: Morcs and Morality*, 347 ANNALS AM. ACAD. POL. & SOC. SCI. 1, 4 (May 1963) ("The great watershed of the activity of organized crime in the United States was the year when Prohibition was passed. The Eighteenth Amendment created a vacuum into which criminals stepped with force and vigor"); Alvin J. T. Zumbun, *Maryland: A Law-Enforcement Dilemma*, 347 ANNALS AM. ACAD. POL. & SOC. SCI. 58, 59 (May 1963) ("In the 1920's, we had the Volstead Act. It was an unenforcible [*sic*] statute which provided bootleggers with funds needed to finance a criminal empire. That mistake was corrected through legislation."); Virgil W. Peterson, *Chicago: Shades of Capone*, 347 ANNALS AM. ACAD. POL. & SOC. SCI. 30, 32-34 (May 1963). But Prohibition also spawned political empires: Joe Kennedy, patriarch of the Kennedy clan, made a sizable chunk of his fortune as a rum-runner. NELLIE BLY, *THE KENNEDY MEN: THREE GENERATIONS OF SEX, SCANDAL AND SECRETS* 16 (1996); DORIS KEARNS GOODWIN, *THE FITZGERALDS AND THE KENNEDYS* 511-515 (1987).



The Constitution of the United States is our accepted codification of basic rights. It guarantees broad personal liberties<sup>21</sup> and limits the scope of the federal government.<sup>22</sup> It is not within the government's power to take the steps needed to implement a policy based on health as a non-good or positive right. Simply put, such a positive right is inconsistent with the Constitution as currently configured.<sup>23</sup> Even the federal government's broadest grant of authority, the Commerce Clause,<sup>24</sup> cannot plausibly encompass a "health police power." To expect the government to conduct itself as if health were a positive right is to advocate, knowingly or unknowingly, a significant alteration of the Constitution.

### **Health as a Merit Good -- The Social and Moral Dimensions of Health**

Another school of thought accepts the premise that health can be valued, but rejects the notion that it can be bought and sold. This is a result of health's "social dimension," or the impact of individual health on society. Theorists who view health as a "special" good fall into two categories: those who justify restrictions on alienability for practical and/or economic reasons, and those who justify restrictions on moral grounds.

### **Economic Justifications**

There are at least three justifications for refusing to countenance a "health market" that incorporate an explicit or implicit economic analysis: externalities, risk of error, and democratic considerations.

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<sup>21</sup>These liberties include speech, U. S. CONST. AM. I CL. 2, association, U. S. CONST. AM. I. CL. 3, and marital privacy, BARRON ET AL., *supra* note 18, at 410-18.

<sup>22</sup>This is true both procedurally (*i.e.*, the federal government cannot try a man twice for the same crime, U. S. CONST. AM. V CL. 2, and only the House of Representatives has the power to impeach, U. S. CONST. ART. I § 2 CL. 5) and substantively (*i.e.*, "Congress shall make no law respecting an establishment of religion," U. S. CONST. AM. I CL. 1).

<sup>23</sup>As Wing notes, "the principle remains that the federal government must operate within its enumerated powers, and federal government activities must be justified in terms of one or more of the explicit provisions of the Constitution." KENNETH R. WING, *THE LAW AND THE PUBLIC'S HEALTH* 18 (3d ed. 1990).

<sup>24</sup>*See Wickard v. Filburn*, 317 U.S. 111, 63 S. Ct. 82 (1942); BARRON ET AL., *supra* note 18, at 97-106.

### Externalities of Health

The first and most important justification is the argument that individual health has a "social dimension." In other words, health has external effects or "externalities" that cannot be fully captured by the price it would command on the open market.<sup>25</sup> The support for health as a special class of goods is based on hardheaded assessments of health's economic repercussions:

Improved health has positive externalities: a fiduciary basis for the alleviation of pain and suffering, rehabilitation, employment of large numbers of people in skilled and unskilled useful labor, a market for goods produced as a result of research, education and innovation, social justice and political stability. As such, health care is a "merit good" and unlike economic goods, its distribution should not be left to the market.<sup>26</sup>

Commentators who consider health a non-marketable good contend that there are elements of health which, though valuable, are unquantifiable, such as hope, compassion, and the extension and preservation of life.<sup>27</sup> Others cite practical benefits by holding that health care is a right, and by arguing that "spending for maternal and child health services and the working-age population is a good investment in economic growth."<sup>28</sup> Health's social benefits are not fully realized by the market price it commands. Because the full social value of health is greater than its economic value and price, market transactions in health should be curtailed or prohibited.<sup>29</sup> This concept has been termed "partial market-inalienability," a state in which health is "incompletely commodified."<sup>30</sup> The sale of such goods may justifiably be regulated in the interests of both the public and the individual.

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<sup>25</sup>Melvin Horwitz, *Corporate Reorganization: The Last Gasp or Last Clear Chance for the Tax-Exempt, Nonprofit Hospital?* 13 AM. J. L. & MED. 527, 534 (1988).

<sup>26</sup>*Id.* (footnotes omitted).

<sup>27</sup>Stuart Rome, *Medicine and Public Policy: Let Us Look Before We Leap Again*, 42 MD. L. REV. 46, 48 (1981).

<sup>28</sup>Battistella, Begun & Buchanan, *supra* note 10, at 68.

<sup>29</sup>Maja Campbell-Eaton, Note, *Antitrust Certificate of Need: A Doubtful Prognosis*, 69 IOWA L. REV. 1451, 1459 (1984).

<sup>30</sup>Radin, *supra* note 9, at 1918 n. 246.

There are significant problems with the premise that the presence of externalities requires health to be viewed as a non-marketable good. This argument seems to misunderstand the nature of economic externalities:

No harmful or beneficial effect is external to the world. Some person or persons always suffer or enjoy these effects. What converts a harmful or beneficial effect into an externality is that the cost of bringing the effect to bear on the decisions of one or more of the interacting persons is too high to make it worthwhile ... . "Internalizing" such effects refers to a process, usually a change in property rights, that enables these effects to bear (in greater degree) on all interacting persons.<sup>31</sup>

The question immediately arises as to whether a problem of externalities can ever be corrected by reducing property rights in the good at issue. Some theorists argue it cannot, because prohibiting the establishment of a clear ownership right "precludes the internalization of external costs and benefits."<sup>32</sup> Ordinarily, a property right internalizes externalities regardless of who holds the possessory interest. The problem of externalities should diminish, not increase, if an individual is forced to take full account of his health status, because the costs of his own conduct will be reflected in insurance premiums, doctor's bills, and his financial compensation. As a result, society will bear more of the burden if health is only incompletely commodified.

### **Risk of Error in Health Decision-Making**

Margaret Radin suggests (but does not advocate) an alternative "prophylactic justification" for market-inalienability of commodities such as "children, sexual services, or body parts."<sup>33</sup> Risk of error is so great in such transactions (because the stakes are so high and so difficult to quantify) that a rule banning all such transactions is justified on pragmatic grounds. According to this argument, health is a good about which ordinary people, who know little, cannot make rational decisions.

There is no reason, however, to believe government can make better decisions. To successfully defend the risk-of-error argument, advocates

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<sup>31</sup>Harold Demsetz, *Toward a Theory of Property Rights*, 57 AM. ECON. REV. 347, 348 (1967).

<sup>32</sup>*Id.* at 349.

<sup>33</sup>Radin, *supra* note 9, at 1910.

must overcome two hurdles. First, to improve on an individual's health-related decisions, expert bureaucrats would need superior information concerning the individual's current situation, future prospects, and fluctuating desires. That is to say, the health decision-maker must have detailed, current information about both the medical and the non-medical situation of each individual -- a daunting prospect, and perhaps a frightening one. Second, it is difficult to formulate an acceptable moral justification for coercing an individual into an uncertain situation or treatment on the basis of a bureaucratic determination of need or want. Radin correctly describes the risk-of-error justification as "deeply troubling," because it ultimately posits some overarching force that can better gauge the desires and wants of persons who are otherwise willing to make a given sale.<sup>34</sup> It is functionally impossible for a bureaucrat to consistently make utility-maximizing choices on the behalf of others.<sup>35</sup> The "marvel" of the market is that individuals, acting without the benefit of master plan or director, still arrive at allocation solutions superior to those that any (human) planner or planners could accomplish.<sup>36</sup>

### The Democratic Implications of Health

A third, closely-related justification for market-inalienability is advanced by Wendy Mariner, who notes that good health is essential to "normal, species functioning."<sup>37</sup> According to Mariner, "[i]n order to carry out any personal or social goals or take advantage of any opportunity, people must be able to function normally."<sup>38</sup> Health is a good, but it is also a precondition to any form of meaningful social activity. Thus, protection of individual health becomes a major unspoken premise in the formation of civil society. In order for government to continue to function, the health of the citizenry must be preserved; and since a person's health has implications that reach beyond his personal well-being, the circumstances under which that person will be able to sell his health are to be strictly limited. This is because political rights can only be enjoyed by healthy people:

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<sup>34</sup>*Id.* at 1910-11.

<sup>35</sup>FRIEDRICH A. HAYEK, *THE CONSTITUTION OF LIBERTY* 254-257 (paperback ed. 1978); Friedrich A. Hayek, *The Use of Knowledge in Society*, 35 *AM. ECON. REV.* 519, 520-24 (1945).

<sup>36</sup>Hayek, *The Use of Knowledge in Society*, *supra* note 35, at 527.

<sup>37</sup>Mariner, *supra* note 11, at 371 (citing N. DANIELS, *JUST HEALTH CARE* (1985)).

<sup>38</sup>*Id.* at 372.

Health care ... differs from ordinary consumer goods ... . A person's need for health care is usually involuntary.\*

[\*It is questionable whether even illnesses associated with certain behaviors, such as smoking and obesity, are the result of voluntarily assumed risks ...]

In short, adequate health care is as essential to survival as the necessities of food, clothing and shelter. These subsistence goods and services are prerequisites to the enjoyment of freedom and the ability to participate in the political process. Without these essentials, there is no liberty -- to vote, hold office, speak one's opinion, observe religion, find employment, or exercise any other right. Absent any of these rights, the range of opportunities open to any person narrows to the vanishing point.<sup>39</sup>

By implication, though health is a good, individual health is also a necessity and, therefore, must be protected in a democratic society. This "serves to explain why health care is not just another economic good which may be distributed according to the market without regard to need."<sup>40</sup> Just as government cannot permit the sale of votes and preserve a democratic society, it cannot permit the sale of an individual's health. Good health is a precondition to equality of opportunity and as such, the government is obligated to secure it for all citizens to the extent feasible.<sup>41</sup> Organ sale, risk-seeking behaviors, and smoking all pose significant threats to democracy, and not merely to the individuals engaging in them.

The emphasis on health's democratic implications is somewhat incoherent. It is driven by the belief that some transaction types are morally superior to others. In fact, most justifications of viewing health as a special good rely on distinguishing between different types of transactions. For instance, though market transactions are socially harmful, certain categories of gifts are socially desirable. Thus, one can give away health but not sell it, donate organs but not sell them.<sup>42</sup>

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<sup>39</sup>*Id.* (some footnotes omitted; bracketed section is footnote 122 in the original).

<sup>40</sup>*Id.* at 373.

<sup>41</sup>*Id.* at 371-5.

<sup>42</sup>This is the current state of things, as discussed in, e.g., David E. Chapman, Comment, *Retailing Human Organs Under the Uniform Commercial Code*, 16 J. MARSHALL L. REV. 393 (1983).

Radin argues that this result is compelled by an inborn moral sense, a contention discussed in more depth below.<sup>43</sup> Here, however, it suffices to note the distinction between gift and sale is not compelled by any moral sense, but rather by a basic misunderstanding of the nature of trade. By definition, trade makes both sides better off, else, absent coercion, it would not occur.<sup>44</sup> "In fact, trade occurs because participants find it mutually attractive, because people place different marginal valuations on scarce goods."<sup>45</sup> By depriving an individual of the ability to sell health-improving services, these theorists envision a regime willing to deprive an individual of his well-being. It is not obvious that the homeless veteran would be worse off with one kidney and \$1 million, as opposed to two functioning kidneys and a life of destitution. Even less clear is the metric by which any government can rationally make such decisions.

Moreover, the distinction between gift and sale is logically flimsy. If a person gives a gift with the intent to alter the recipient's behavior in his favor, has he provided a gift; or has he, in effect, purchased goodwill? Distinguishing between gift and sale is possible, but the line drawn is arbitrary. These commentators merely favor certain transactions, such as exchange of goods for services or goodwill, over others, such as exchange of goods for money.

Finally, the prevention of trade denies the individual a property right in the most personal, and surely the most privately owned, part of the universe: his own body. This invasive element of health's "democratic" dimension, that in the context of individual health democracy requires rigid social controls, is profoundly antidemocratic.

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<sup>43</sup>Radin, *supra* note 9, at 1880.

<sup>44</sup>Coercion, of course, is precisely the response most commentators are likely to provide, when pressed on this point. The question then becomes whether asymmetry of bargaining power implies coercion. It may, but there is no necessary reason to believe that it does. Hayek notes, "we are dependent for the satisfaction of most of our needs on the services of some of our fellows. ... . The benefits and opportunities which our fellows offer to us will be available only if we satisfy their conditions ... . [It is not] 'coercion' if a producer or dealer refuses to supply me with what I want except at his price. This is certainly true in a competitive market, where I can turn to somebody else if the terms of the first offer do not suit me; and it is normally no less true when I face a monopolist." HAYEK, *supra* note 35, at 135-6. Hayek acknowledges a distinction in cases of life-threatening illness or strict necessity.

<sup>45</sup>ARMEN ALCHIAN & WILLIAM R. ALLEN, EXCHANGE AND PRODUCTION: COMPETITION, COORDINATION, AND CONTROL 45 (3d ed. 1983).

### Moral Justifications

As we have seen above, the economic arguments in favor of treating health as a merit good rest on a flawed economic belief and a series of implicit moral judgments, like that favoring gift over sale. The risk-of-error justification also has an unstated moral dimension. Accepting that mistakes will be made, who has the moral prerogative to make potentially life-threatening health decisions: the individual or the state? Although they do not explicitly say so, theorists relying on the risk-of-error justification conclude the moral authority to make health-related decisions should repose in the state. Other commentators build their justifications on more explicit moral arguments.

Radin, for example, posits a “domino theory,” whereby the market conception of one “borderline” good leads to a universal market regime.<sup>46</sup> This is to be avoided because some transactions are less worthy when undertaken in a market context. To permit market transactions will cheapen the corresponding non-market transaction involving the same good. A non-commodified good is “morally preferable”<sup>47</sup>: for Radin, blood donation is morally better than blood purchase, and selling organs reduces the selflessness and nobility of organ donation.<sup>48</sup> However, the notion that the absence of a market alternative generates altruism can apply with equal force to almost any transaction.<sup>49</sup> Radin’s argument against commodification *per se* “leads to universal noncommodification.”<sup>50</sup> In turn, universal non-commodification leads logically to a regime in which health is a positive right.

Other commentators argue that “health care is a social good that should be equitably distributed”<sup>51</sup> for unstated moral or ethical reasons. Melvin Horwitz, for one, contends

[M]edical care is not just another economic good that is bought and sold in a competitive marketplace. Our society protects the sick patient with numerous legal constraints and ethical precepts. Improved health, not profits, is the primary goal of the health care system ... . Furthermore, markets provide goods and services at

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<sup>46</sup>Radin, *supra* note 9, at 1912-13.

<sup>47</sup>*Id.* at 1913.

<sup>48</sup>*Id.* at 1913-14.

<sup>49</sup>*Id.* at 1914 n. 235.

<sup>50</sup>*Id.* at 1912.

<sup>51</sup>Horwitz, *supra* note 25, at 557.

prices attractive enough to entice the customer to purchase an item. The ethical health care provider has the additional obligation to see that sick patients get the care they need. This distinction is important. "Markets are driven by customers' wants; the health care system is supposed to consider health needs."<sup>52</sup>

This argument contains several important fallacies. Primary among them is that Horwitz attempts to distinguish between "wants" and "needs" in a health market. Certainly, plastic surgery is a need of a different order than heart surgery. However, Horwitz's claim would seem to extend beyond the premise that physicians should do what is biologically necessary, and require doctors (and the health care system more broadly) to act out of an inborn benevolence. His confidence in the charitable impulses of health care providers is admirable, but is obviously not preferable to a market-driven system of health provision.

Markets are driven by trade: people exchanging property rights in such a manner that both expect to be better off as a result of the transaction. This framework holds regardless of what is actually traded. A health market is more likely to attend to peoples' needs than is a bureaucratic system, since only in the former does the individual have a meaningful way of translating his demands into concrete services. A benefit of this view is that it does not require health care providers to be of better moral stock than the rest of us; good medical care (and thus, usually, better health) will arise from the self-interest of physicians, rather than from the rarefied altruism Horwitz sees as a prerequisite of medical practice.

Further, the existence of "legal constraints" does not, as Horwitz would have it, contradict health's status as a good. That felons cannot purchase firearms, or children under sixteen years of age cannot drive cars, does not affect the status of motor vehicles and handguns as economic goods. The legal constraints (and legal protections) of which Horwitz writes do not affect the character of health or health care. Rather, they speak to the question of responsibility. Legal rules, in this context, do no more than hold injurers responsible for the harm they cause. At an

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<sup>52</sup>*Id.* at 533-4 (footnotes omitted). Note that Horwitz is denying a claim that is far less broad than the one we are discussing here: he rejects the premise that health *care* is a good. *See also* Battistella, Begun & Buchanan, *supra* note 10, at 68 (pointing to Kenneth Arrow and Talcott Parsons as the best-recognized defenders "of the idea that health is a social good").



extreme, such rules may also decide who shall pay for a given good or service (e.g., the government, the individual, or a culpable third party). However, the existence of legal constraints does not suggest an answer to the question of whether health is an "economic good that is bought and sold in a competitive marketplace." Restated, the question becomes: who shall be held liable when an individual, though his own actions, causes harm to himself? Is the locus of responsibility for an individual's health the individual or the state?

In addition, Horwitz's focus on profits as a pernicious influence is misplaced. Profits are a means of signaling that more capital and effort should be allocated toward the fulfillment of a particular want or need.<sup>53</sup> If a health market is allowed, profits will guide investors and fledgling professionals to those subject areas and geographic locations where consumers' wants and needs are most acute. Indeed, "improved health" is inseparable from profits, since high-caliber health care providers flourish while those causing injury rapidly collapse under the weight of lawsuits and patient departure.<sup>54</sup> Capitalism does not preclude charity; rather, it requires an organization to be self-sufficient. Michael Morrissey's syllogism, "No margin, no mission," demonstrates how even a person motivated wholly by charitable impulses must produce enough revenue to sustain himself.<sup>55</sup> Absent profit, little energy would be expended to provide for the health of the populace. This is precisely Horwitz's major concern.

Finally, the ethical obligation of a physician to provide needed care does not conflict with his participation in the marketplace, any more than does a lawyer's ethical duty to perform services *pro bono*. The job of the health care provider carries certain responsibilities toward the individual patient. These responsibilities are commonly accepted and, at times, will lead to the provision of services without remuneration. It is important to realize, however, these costs are already part of the market's valuation of such services. Consequently the costs do not and cannot function as an

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<sup>53</sup>LUDWIG VON MISES, HUMAN ACTION 290 (1949) (referring to "psychic profit" and "psychic loss" in the absence of monetary profit and loss).

<sup>54</sup>If "every family has a free and fair choice among competing health plans, organizations that make a practice of underserving their members will not last long." ALAIN ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 69 (1980).

<sup>55</sup>MICHAEL A. MORRISSEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC 18 (1994).

argument against allowing the market to gauge the value of services *per se*.

### **The Middle Ground is Quicksand**

The middle-ground position, that health, though technically a good, is not or should not be marketable, is simply untenable. The phrase “non-market good” refers to a property right insufficiently vested or held in common in such a way as to render it unmarketable. In the context of health, this means an individual’s health is jointly held by that individual and by his government. But because the government has primary property rights in health, the individual cannot market it. For practical purposes, this is government ownership of individual health. With the connection between responsibility and ownership severed, few of the costs associated with health-related behaviors will be borne by the individual. The system will accomplish precisely what it is designed to avoid, ensuring maximum externalization rather than accurately valuing individual health. A joint ownership system cannot provide the proper incentives to motivate an individual’s efficient maintenance of health.

The view of health as a merit good reflects the sentiments of authors who believe health care should be subsidized in some way, whether by government intervention or by voluntary action. These theorists object to the notion that health can be traded on the open market, not because it cannot be, but because it should not be. However, their objections to the concept of health as a salable good are based on incorrect economic assumptions. Once the errors are corrected, the theorists are faced with two choices: (1) embrace the concept of health as a positive right, thus validating their moral sense but inviting significant governmental intrusion, or (2) re-examine the notion of health as an economic good.

There is no sustainable position between these opposing views of health. As a technical proposition, once the government is allowed any property rights in the health of individuals, the first step down a slippery slope has been taken. In order for the slippery slope argument to be relevant, three conditions must be met.<sup>56</sup> First, the temptation of a perceived improvement must be apparent. Here, such a perception is clear. Proponents of a “mixed” view of health contend society can improve the lives of countless Americans, if we can only accept that

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<sup>56</sup>DAVID LAMB, DOWN THE SLIPPERY SLOPE, 1-9 (1988).

government has some role, and not necessarily a decisive one, in providing for the health of its constituents.<sup>57</sup> Second, the initial step down a slippery slope must violate a previously accepted moral absolute. One's responsibility for one's own actions and their consequences, and by extension for one's physical well-being, is just such an absolute.

Finally, after the moral absolute is breached, there must be a lack of rationally-distinguishable barriers to incremental adjustments of policy. Where is the philosophical barrier between benign involvement and total control, between making minor adjustments in tax treatment and banning entire categories of heretofore acceptable activity? Outlawing any activity with adverse side effects on the health of the participant is logically consistent with government ownership of, and thus responsibility for, individual health. This is true whether the government involvement contemplated is limited or comprehensive. "[O]nce clear-cut absolutes are replaced by indeterminate concepts, moral boundaries can become a playground [*sic*] for sophistry."<sup>58</sup>

### Health as an Economic Good

In this final vision, a person's health is understood as an economic good. "Economic goods" are defined as "all things that we would like to have -- friendships, cleanliness, health, honesty and the like -- and not merely marketable things like milk, shoes, and cars."<sup>59</sup> Health is a commodity valued by comparison with other available goods in a competitive marketplace. In this view, it is perfectly acceptable to buy and sell human organs on the open market.<sup>60</sup> Though the concept of an organ market is superficially shocking, there is an important truth contained in this conception of health.<sup>61</sup> People can and do make rational economic decisions regarding their health status. One can invest in one's health; diet, vitamin supplements, and exercise all directly affect it. Without becoming overly mechanistic, one can reasonably view check-ups as

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<sup>57</sup>This view is implicit in *e.g.*, Horwitz, *supra* note 25.

<sup>58</sup>DAVID LAMB, *DOWN THE SLIPPERY SLOPE*, 4 (1988).

<sup>59</sup>ALCHIAN & ALLEN, *supra* note 45, at 17 n.1.

<sup>60</sup>"[S]ociety should not view the sale of human organs any differently than the sale of other necessary commodities such as food, shelter, and medication." Chapman, *supra* note 42, at 405.

<sup>61</sup>The notion of health as an economic good has, if nothing else, convinced the organizations funding health care: "federal administrators and most industry leaders, who pay the greatest portion of health care bills, consider health care an economic good that is bought and sold in the marketplace, with the government providing health care for the poor." Horwitz, *supra* note 25, at 557 (footnote omitted).

routine maintenance, and surgical and specialty medical procedures as major repairs.

At root, this view contends that virtually everything is a good. Radin refers to it, disapprovingly but accurately, as "universal commodification":

[E]verything people need or desire, either individually or in groups, is conceived of as a commodity. "Everything" includes not only those things usually considered goods, but also personal attributes, relationships, and states of affairs. Under universal commodification, the functions of government, wisdom, a healthful environment, and the right to bear children are all commodities.<sup>62</sup>

Thus, health is a salable good, maintained by purchasing some level of health care. Decisions impacting a person's health are made either individually or in concert with a variety of paid advisers: "Under this model, competitive 'intermediaries' or 'gatekeepers,' such as health plans, insurance companies, or doctors at financial risk, decide through a market with consumers which types of health care are worth their cost. The primary protection for patients against unreasonable underservice is ... market competition."<sup>63</sup>

There is, however, no claim to a perfect market in health, and there are, without question, serious distortions within the health market.<sup>64</sup> The premise that a consumer "will comparison shop for price and quality, purchasing only as much health care as he or she wants,"<sup>65</sup> and engage in exercise and dietary modification only to the extent that the utility of improved health outweighs the disutility of the modifications, bears closer examination.

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<sup>62</sup>Radin, *supra* note 9, at 1860 (footnote omitted).

<sup>63</sup>Rand E. Rosenblatt, *Medicaid Primary Care Case Management, the Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915, 936 (1986) (footnotes omitted).

<sup>64</sup>See Thomas L. Greaney, *Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1509-13 (1994).

<sup>65</sup>Horwitz, *supra* note 25, at 533.

Information is the chief barrier to arriving at rational economic choices regarding an individual's health.<sup>66</sup> Information regarding health is unequally distributed in favor of providers, and is difficult for consumers to acquire and digest.<sup>67</sup> As a result, "decisions are more often made by the physician than the patient ... . [T]hese consumption decisions frequently are made during unexpected, emergency situations, and are not constrained by limited finances due to the availability of health insurance."<sup>68</sup>

Skilled providers are almost always in some form of conflict-of-interest, since they benefit financially from providing additional care. Consumers are radically dependent on the skills and good will of their expert physicians and other care providers.<sup>69</sup> However, no one doubts that stock investments are "goods," and they are also usually made at the advice of experts. A poor choice, made with or without help, does not mean that the decision did not involve a market good; only that the

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<sup>66</sup>Greaney, *supra* note 61, at 1507 ("Market interactions in health care have been distorted by the existence of imperfect and asymmetrically distributed information, the peculiar incentives that flow from the presence of insurance, and other market imperfections") (footnote omitted). Poor information may explain consumers' health choices. Horwitz, for instance, contends that non-profit hospitals persist in part because consumers trust them:

While the prevalence of third-party insurance, tax exemption and tax-free bonding may be the most important reasons for the persistence of the nonprofit form, some authors emphasize the fiduciary role of the nonprofit hospital as justification for their existence.

Patients, lacking comparable medical knowledge, must place their trust in the hospital. Unequipped to evaluate the quality, price or available options, patients choose nonprofit institutions based on the assumption that a nonprofit hospital is committed primarily to the treatment of illness rather than to the maximization of profits, and thus is less likely to take advantage of them.

Horwitz, *supra* note 25, at 530 (footnotes omitted).

<sup>67</sup>Greaney, *supra* note 61, at 1510 (footnotes omitted) ("the information that is available is distributed asymmetrically among providers, patients, and payers. To some extent, this may permit physicians to 'induce demand' for their services; at a minimum this phenomenon makes information costly for buyers to acquire."). Reliance on providers also creates substantial agency problems: "Given the technical nature of medical information, the complexity of diagnoses and treatment alternatives, and the inherent uncertainty surrounding medical judgments, patients and third party payers find it difficult to evaluate the cost and quality of health services." Horwitz, *supra* note 25, at 530 (footnotes omitted).

<sup>68</sup>*Id.* at 534 (footnote omitted).

<sup>69</sup>Greaney, *supra* note 61, at 1511 n. 10; Alan Schwartz & Louis L. Wilde, *Intervening in Markets on the Basis of Imperfect Information: A Legal and Economic Analysis*, 127 U. PA. L. REV. 630, 658-59 n.69 (1979).

decision-maker is not infallible. Even among professionals, "uncertainty often prevails as to the type, amount and duration of required medical care."<sup>70</sup> The available evidence, which is not overwhelming, suggests that, when tried, competition in health care provision works.<sup>71</sup> This provides anecdotal support for the notion that people are able to behave rationally when their health is reconceptualized as private property, that is to say, as their own responsibility.

Consider a farmer, for example, who may deliberately sow his land with salt. We may look upon his actions with puzzlement, or even disgust, but we have no grounds for preventing him from acting as he wishes. Similarly, we have no recourse against an individual who deliberately harms himself or engages in risky, but consensual, sexual practices. The same farmer may harm the value of his land inadvertently; he may, for instance, honestly but mistakenly believe Belgian endive will be the next United States cash crop, and as a consequence, use his property in a way that reduces its value. Again, unless we are strict paternalists, we cannot prevent him from taking this foolhardy course of action, though we (as individuals or collectively) may attempt to dissuade him from it. Similarly, the individual who puts his faith in unproven medicines, or who believes that an all-lettuce diet will extend his life, is beyond our lawful reach.

Society can only become involved in the farmer's affairs when his and use begins to interfere with that of others. If the farmer stages rock concerts on his farm, or plants fast-growing kudzu, his neighbors will have the right to seek to enjoin his behavior, or be compensated for his

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<sup>70</sup>Horwitz, *supra* note 25, at 534.

<sup>71</sup>Critics of market-based reform frequently point to the private sector's abysmal failure to contain costs during the "competitive revolution" of the 1980s as proof of the futility of reliance on competition. However, close examination of insurance practices and provider responses to the incentives of the health financing system reveals a marketplace highly responsive to economic stimuli. Unfortunately, [because] those stimuli were the distorted signals influenced by regulation and ... market imperfections ... competition often produced perverse results.

Greaney, *supra* note 61, at 1513 (footnote omitted). The RAND Health Insurance Experiment proved that health care consumers can be cost-sensitive. EMMETT B. KEELER ET AL., THE DEMAND FOR EPISODES OF MEDICAL TREATMENT IN THE HEALTH INSURANCE EXPERIMENT (RAND R-3454-HHS, March 1988); see MICHAEL A. MORRISSEY, COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC 13 (1994). The RAND experiment leaves open the question of whether consumers will make medically prudent decisions.

interference with their property rights.<sup>72</sup> This final situation is analogous to the case of a smoker in a public place, or a person who deliberately puts others at health risk.

### Practical Objections

Mariner makes the erroneous claim that government involvement in the health market alters health's status as a good. Drawing on early writings by Robert Reich, she contends government benefits cease to be economic goods over time, instead becoming prerequisites for democratic participation. As discussed above, health becomes not only an attribute of democratic citizenship, but an implicit governmental guarantee:

Viewing health care as an ordinary commercial commodity to be distributed in the market is inconsistent with the extensive degree of government involvement in providing and financing health services ... . Changing social conditions demand a newer vision of what is important to effective participation in a democracy. Health care should qualify as an important interest in maintaining one's ability to take advantage of opportunities that are theoretically equally available to all.<sup>73</sup>

Accepting the premise that people now view good health as an entitlement does not affect the question of whether or not health is an economic good. Indeed, it clarifies the government's role with regard to health. If health is an economic good, and people nevertheless view it as an entitlement (not unlike food or shelter), then the foundations are set for a form of "health welfare." However, this project cannot come from the federal government absent changes in the structure of our governmental system.

Others raise the concern that viewing health as an economic good will lead to a decline in the amount of available health-related information, rather than an increase. Such a "voucher system explicitly encourages people to conceive of health care as a private market transaction between an individual patient and a health care provider or insurance company. The very capacity of our culture to inform itself

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<sup>72</sup>See Ronald Coase, *The Problem of Social Cost*, 3 J.L. & ECON. 1 (1960) (contending that, in principle, any allocation of initial property rights in a free market will result in an efficient solution to problems of nuisance or interference with property).

<sup>73</sup>Mariner, *supra* note 11, at 379-80 (1986) (footnotes omitted; citing Robert Reich, *The New Property*, 73 YALE L. J. 733 (1964)).

about patterns of health and health care and to mount a public response would possibly be lost in the 'stark utopia' of radical privatization."<sup>74</sup> The "radical privatization" of what is now either a non-good or a merit good would "undermine our cultural capacity to perceive the social patterns of health problems not only as a matter of thought, but also as a practical matter of data collection."<sup>75</sup> This argument fails to acknowledge that consumers would have a greater incentive to inform themselves if they become responsible for their own well-being. Though government sources of information might dry up, private information agencies are likely to arise to provide information to consumers.

Finally, some predict the quality of care will inevitably decline if health is commodified. Quality is incompatible with this conception of health: "if society treats medical care solely as an economic good and physicians share in the profits of health care organizations, the quality of care will suffer."<sup>76</sup> This prediction, however, does not appear to hold with any other service. Private mail carriers, such as Federal Express and United Parcel Service, are at least as competent as their counterparts in the United States Postal Service. Likewise, there is no obvious reason to believe that private sector lawyers are substantially worse than those who choose to work in the public sector. Also, quality is not the sole concern in a health system, because health is not infinitely precious. The balance between quality and cost can be set more rationally by self-interested consumers than by bureaucrats.

### Moral Objections

There is also a significant moral dimension to the condemnation of the economic view of health. The moral objection is hardest to respond to because it ultimately reflects the first principles of the authors and perhaps, of the American public.<sup>77</sup> Some contend that viewing health as an economic good will undermine equal opportunity:

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<sup>74</sup>Rosenblatt, *supra* note 60, at 968 (footnotes omitted).

<sup>75</sup>*Id.* at n. 248.

<sup>76</sup>Horwitz, *supra* note 25, at 534-5 (footnote omitted).

<sup>77</sup>"Most Americans consider access to a decent level of medical care to be a part of the right to 'life, liberty, and the pursuit of happiness.' ... [W]e are not willing to leave the distribution of medical purchasing power to the market and other forces that determine income distribution." ENTHOVEN, *supra* note 54, at 81. Enthoven, it should be noted, is "a strong proponent of market competition as the preferred means of organizing and distributing health care." Rosenblatt, *supra* note 60, at 917 n.1.



[T]he importance of basic health care to the preservation of opportunity creates a moral obligation on the part of society to insure the provision of health care services to maintain or restore normal species functioning. If justice requires that everyone enjoy fair equality of opportunity, then a just society must distribute its health care services so as to maintain normal species functioning.<sup>78</sup>

The objection seems not to have grasped the full implications of accepting the economic-good model of health. Equality of opportunity is not harmed by private ownership of health, since health would not cease to be valuable, by any means. Rather, it would become another species of personal property, to which ordinary legal protections and rights would apply. A smoker, in this view, is free to harm his own property, but he cannot behave as a public or a private nuisance, and he is certainly not entitled to government aid if he ends up damaging his property (*e.g.*, his health) beyond repair. Ordinary tort-law and municipal remedies can deal quite adequately with health-related grievances, in the same forum and using the same rules of law that have guided Anglo-American civilization for centuries. Health is thus easily placed in the broader context of American social and civic life, without resorting to complicated government schemes or the creation of new entitlements or Constitutional rights.

Of course, some object more basically to the distinction between tort and non-tort. Abel suggests that the American legal system should compensate people for their misfortunes, regardless of a misfortune's cause. Thus, harm caused by an unavoidable accident or by another person's deliberate action is treated in the same way as deliberate self-harm. Abel opposes the principle of assessing court damages based on pain and suffering, because such awards "commodify our unique experience," and cheapen it in some sense.<sup>79</sup> In effect, this proposal is a rejection of the entire common-law system of dispute resolution; it is not clear that Abel has provided for an adequate alternative to stave off a return to vigilantism and vendetta.

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<sup>78</sup>Mariner, *supra* note 11, at 372.

<sup>79</sup>Richard Abel, *A Critique of American Tort Law*, 8 BR. J. L. & SOCIETY 199, 207 (1981); see Radin, *supra* note 9, at 1876 (discussing Abel).

Radin locates the objection to the market conception of health in the intuitive sphere: "for all but the deepest enthusiast, market rhetoric seems intuitively out of place here, so inappropriate that it is either silly or somehow insulting to the value being discussed."<sup>80</sup> Unfortunately, Radin's "argument" here is in fact a simple value judgment. That Radin finds the notion of "personal attributes as fungible objects" to be "intuitively wrong" does not render it either empirically inaccurate or useless as a conceptual tool. Radin's dislike of the notion of health as an economic good is visceral.

Using rape as an example of a situation in which "bodily integrity" cannot be seen as a "fungible object," she writes:

Thinking of rape in market rhetoric implicitly conceives of as fungible something that we know to be personal, in fact conceives of as fungible property something we know to be too personal even to be personal property. Bodily integrity is an attribute and not an object. We feel discomfort or even insult, and we fear degradation or even loss of the value involved, when bodily integrity is conceived of as a fungible object.<sup>81</sup>

For Radin, viewing health (or other bodily attributes) as a commodity is "threatening to personhood, because it detaches from the person that which is integral to the person."<sup>82</sup> At root, she is framing a slippery-slope argument: "if my bodily integrity is an integral personal attribute, not a detachable object, then hypothetically valuing my bodily integrity in money is not far removed from valuing me in money. For all but the universal commodifier, that is inappropriate treatment of a person"<sup>83</sup> But tort laws, actuarial tables and insurance contracts all value people in money, without the dire consequences Radin predicts.

Radin acknowledges that absent some limit-setting tool, pervasive regulation in favor of health is inevitable. She proposes "human flourishing" as her yardstick: health-related policies should be evaluated by determining to what extent they limit or advance human flourishing.<sup>84</sup> Radin concludes that human flourishing demands that health, and the body

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<sup>80</sup>Radin, *supra* note 9, at 1880.

<sup>81</sup>*Id.* (footnotes omitted).

<sup>82</sup>*Id.* at 1881.

<sup>83</sup>*Id.*

<sup>84</sup>*Id.* at 1884.

in general, be viewed as a market-inalienable good, which can be given but not sold.<sup>85</sup> Unfortunately, this "standard" is impossible to independently identify and describe. We must, as a society, wait for Professor Radin and others to tell us precisely what is required for humans to flourish.

The concept of human flourishing seems to be reducible to the proposition that people should be permitted to seek those right-thinking activities that improve their minds or expand their spirits, and may be prevented from taking acts that do not. This is an idea with a distinguished, if undemocratic, pedigree whether discussed in terms of Marx's "false consciousness,"<sup>86</sup> Rousseau's "forced freedom,"<sup>87</sup> or Plato's reign of the philosopher.<sup>88</sup>

In this way, Radin raises the question of accountability. If the individual makes a decision that ends in an unsatisfactory outcome, it is his own fault and he shoulders the responsibility. If his well-being or life is placed in jeopardy by a decision of the state, he has no recourse and is simply a victim. The state cannot, by its nature, be held accountable for

<sup>85</sup>"Market rhetoric, the rhetoric of alienability of all 'goods,' is also the rhetoric of alienation of ourselves from what we can be as persons." *Id.* at 1884-5 (footnotes omitted).

<sup>86</sup>*Cf.*, e.g., ERICH FROMM, MARX'S CONCEPT OF MAN 20-21 (1969) ("It should be noted that Marx ... believed that most of what men consciously think is 'false' consciousness, is ideology and rationalization; that the true mainsprings of man's actions are unconscious to him. . . . [A]ccording to Marx, they are rooted in the whole social organization of man which directs his consciousness in certain directions and blocks him from being aware of certain facts and experiences").

<sup>87</sup>"[W]hoever refuses to obey the general will shall be constrained to do so by the entire body; which means only that he will be forced to be free." JEAN-JACQUES ROUSSEAU, ON THE SOCIAL CONTRACT 55 (Roger D. Masters ed. & Judith R. Masters trans., St. Martin's Press 1978) (1762).

<sup>88</sup>R. C. CROSS & A. D. WOOLEY, PLATO'S REPUBLIC: A PHILOSOPHICAL COMMENTARY 108-109 (1964) ("It is not over-cynical to conclude that Plato thought it was more important that the most competent men should rule than that less competent men should have a say in deciding who should rule; and that the freedom accorded to the Economic Class was an exceedingly limited or even spurious freedom, the freedom which they would be allowed only for so long as they used it in the way which Plato wanted.")

Radin's vision is reflexively left-wing. Thus, Radin indicates that "we should not accept a conception of human flourishing that excludes our understanding of politics as (also) community self-determination, excludes our understanding of reproductive capacity as essentially human and personal, and excludes our understanding that the pain of witnessing criminal acts and unjust institutions is not like the price of shoes or snowplows." Radin, *supra* note 9, at 1884 n.131. Abortion becomes an integral part of "human flourishing," rather than merely a contested political issue. Radin's article never supplies a satisfactory definition of "personhood." *See id.* at 1909-10. Without such a definition, her argument is ultimately reliant on her own conviction that her political intuitions are superior -- an unstated belief that she should be (or at least could be) philosopher-king.

such decisions. Accountability can only be secured if health is an economic good, and it comes at the inevitable cost of security. If health is an economic good, people should be able to bargain it away. Private parties would, in this model, be able to contract as to the amount of risk each is willing to take.<sup>89</sup> They will be held responsible for the full implications of their own decisions. This is perhaps a more frightening world than that envisioned by the theorists we have discussed, but it is also a world in which legal consistency and freedom are enhanced.

### CONCLUSION

Considering these three views of health, it becomes clear that only two can produce viable public policy options. Health must be viewed as either a socially-guaranteed positive right and, thus, as a non-good, or as an economic good and, thus, as personal property. The impulse to find a middle ground is quite understandable, since both conceptions are, in their own ways, quite harsh. However, there is no conceptually reasonable way to split the difference: either a person is entitled to good health, or he is entitled to do what he likes with his health. The economic view of health implies a world in which we, as a society, accept the prospect of people making catastrophic mistakes about their own well-being. The non-economic view of health implies a government that involves itself deeply and intimately in the lives of its citizens, in ways inimical to personal liberty. Policy-makers should be clear as to what philosophy of health underlies their plans.

America has seen several proposals to alter the way health is viewed and the way health care is provided.<sup>90</sup> To reiterate, there is no middle ground, and each vision of health leads to a fundamentally different set of ideas for what is to be done. Whichever view our society chooses to embrace is a matter of both personal philosophy and public policy. Before the next round of health reform we must all decide where we stand.

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<sup>89</sup>Rosenblatt, *supra* note 60, at 930, n.57 (discussing "a new generation of proposals to allow modification of malpractice standards by contracts between providers and patients").

<sup>90</sup>Litman, *supra* note 7, at 15-18.

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