A wise man should consider that health
is the greatest of human blessings.

—Hippocrates

Health

The Value at Stake

ERIKA BLACKSHER

Few dispute the need for health care reform in America. Two problems—access and cost—attract the most commentary, and for good reasons. The ranks of uninsured Americans, which have increased annually for the last six years, are likely to reach 50 million in this economic downturn, and health care expenditures are predicted to top $2.5 trillion in 2009. Both problems are unsustainable features of American health care. But these problems share company with a third that has gone largely overlooked. Our health system, if it can be so called, is not designed to produce *health*. Indeed, health *care* is but one determinant of health, and by some measures it is a relatively minor one. Despite the trillions spent on medical services, the United States ranks poorly on key measures of health. For example, according to 2004 World Health Association data, the United States ranks forty-sixth in average life expectancy out of 192 nations.

Addressing this gap in our national health reform debate requires a fundamental reorientation in our thinking about health care and its relationship to health. Reform needs to include measures that will help keep people healthy and better manage their illnesses should they fall ill. We should standardize insurance benefits, refocus services on primary care, reward the management and prevention of chronic disease, create information systems that track patient populations, expand community health centers. We should also assess (and act on) the health impact of policies in sectors other than health care, such as taxation, agriculture, housing, urban planning, transportation, and education. Such reforms will not only produce a healthier nation but also reduce the stark health inequalities that separate Americans who are better off from those who are worse off.

Erika Blacksher, PhD, *is a research scholar at The Hastings Center and a former Robert Wood Johnson Health and Society Scholar at Columbia University.*

Health and Value

This perspective on health system reform turns on a value rarely identified, defined, or defended in explicit terms. That value is health itself. Health is thought to be a good in several respects. First, people may value health because it contributes directly to their sense of well-being; in this sense, it is an *intrinsic* good—a good that people enjoy for itself. But even if people do not consciously appreciate their health when they have it, losing it will make them aware that they rely on some level of it to pursue their interests and to act on their plans. Health, in this sense, is also an *instrumental* good that enables people to manage and control their lives. Health is also a *collective* social good that can contribute to a nation's productivity and reduce absenteeism and health care costs.

Health may seem too simple an idea to define or too obvious a value to defend in a debate over health system reform. Questions abound, however, about how to define and produce it and how to balance it with other values. Is health an expansive idea that relates to human well-being, or a narrow idea that relates to bodily function? The World Health Organization defines health as "a state of complete physical, mental and social well-being and not

merely the absence of disease or infirmity." Critics charge that the WHO account is too vague and reduces all dimensions of well-being to health; they define health more narrowly as the absence of disease. But both approaches involve value judgments that are likely to be contentious. WHO's definition requires well-developed ideas about the good life; the narrower, biomedical constructs require consensus on notions such as what counts as normal functioning and what counts as suffering. Still other definitional complexities and controversies exist. But no matter how we measure health, the United States compares poorly to other wealthy countries and even to some middle- and low-income countries.

Health care is but one determinant of health, and by some measures it is a relatively minor one.

While we need not agree on a particular concept of health in order to agree that we are an unhealthy nation, how we conceive of health has implications for how we think about improving it. Because the biomedical conceptions of health rest on conceptions of disease and disability, they run the risk of channeling our collective attention and action toward medical services that respond to disease and disability—and away from broader social systems that prevent disease and promote health. Universal access to timely, high-quality primary care certainly would help to improve health outcomes and reduce health inequalities. But even with universal coverage, disparities in disease and injury will remain because it takes more than health care to ensure health. For example, medical services make a mere 10 to 15 percent contribution to reducing premature death. In addition, factors that contribute to health include health-related behaviors, genes, and social, economic, and environmental conditions.

The pursuit of health equity in this political culture will have to negotiate a number of American values likely to supply resistance. One source of resistance will be those who view such policies as an infringement on individual liberty. The precise meaning of liberty may take slightly different forms, depending on the different objections. Policies that ban products (such as trans fats) or that regulate activities (such as driving without a seat belt) may be said to interfere with individuals' freedom of choice. Others may take aim at government programs and the taxes they entail, based on a principled rejection of the role of government, save its activities related to national defense, law enforcement, and judicial institutions that protect individual rights. These positions share a concern with what people are free *from* and may find common cause with a second plank of resistance to any robust health equity agenda—the view of health as individual responsibility. Individuals, not the state, are responsible for improving their health, and if they fail at that, it is individuals who must shoulder the consequences.

Of course, everyone knows of people who have managed, even against great odds, to change deeply ingrained ways of living and improve their health. But many people don't manage that, and members of socioeconomically marginalized and minority groups are disproportionately among those who maintain poor health habits. This fact should cause us to rethink and reframe the question of responsibility and how we think about liberty. The significance of class and race for health habits does not suggest that members of socially disadvantaged groups are all choosing in lockstep; rather, it suggests that their choices are systematically constrained by living, learning, and working conditions that can limit people's choices and perhaps the freedom expressed in those choices. Policies that remake these social conditions—for example, ensuring that everyone has a nearby grocery store that sells fresh produce, a primary care physician, a pharmacy, and safe venues for recreation and social gatherings—can enhance people's freedom to make healthier choices. So some forms of collective action can *enhance* people's liberty.

That these social conditions are often the product of widely endorsed public policies suggests that the call for personal responsibility should be accompanied by an awakening of our sense of shared responsibility. The idea is not foreign to U.S. political culture; indeed, it seems to be at the center of our new president's philosophy. President Barack Obama has called for a "new era of responsibility" that makes demands not just of individuals, but also of families, communities, and society at large. This big-tent conception of responsibility should be directed at promoting health for all.

★ Policy Implications ★

The social determinants of health are particularly salient in this era of chronic disease, whose causes can be traced to the conditions in which we grow up, live, learn, work, and play. Health habits related to diet, exercise, and tobacco use make an indisputable contribution to the onset and progression of chronic diseases and help explain some of the disproportionate disease burden among lower socioeconomic groups. But health habits do not explain all of it. Low socioeconomic status itself contributes to premature mortality and excess morbidity. Researchers do not yet know which markers of class exert the most profound influence on health, but low educational attainment, low-wage jobs, poor-quality housing, and polluted and dangerous neighborhoods, along with the stress and social isolation these experiences may induce, all plainly play a role. The vagaries associated with being

poor or near poor exact an especially heavy toll on the health and development of children, often with lifelong effects.

If the organizing principle of health reform is the production and the fair distribution of health, then we will need to rethink what a health system is. What might such a system look like and what sort of policies would it entail? Promising policies and programs have been recommended, and some are already being implemented in states and cities around the country. These interventions include measures aimed at several different levels. Some focus on neighborhood conditions: they seek to improve housing stock, create safe areas for exercise, and enhance the food supply (such as by banning trans fats and by supporting farmers' markets, for example). Other interventions focus on at-risk families and children, by providing income supports, securing nutrition, and enriching educational environments and opportunities. Yet other possible interventions promote educational attainment and improve work conditions and benefits for adults. These measures cannot guarantee health for all. But they can promote a fair *opportunity* for health for all. And that is a very American value.★