HEALTH REFORM AND HEALTH EQUITY:
SHARING RESPONSIBILITY FOR HEALTH IN THE
UNITED STATES

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I. INTRODUCTION

Two failings of U.S. health care have defined recent reform efforts: the escalating cost of health care—estimated to have reached $2.5 trillion in 2009—and the swelling ranks of uninsured and underinsured Americans, now totaling some seventy-five million people. They share company with a third, however, that has attracted little attention. Tens of millions of poor and minority Americans experience levels of health typical of middle- or low-income countries. Differences in health status by social class, race and ethnicity, and geographic region are large and persistent in the United States. Guaranteed access to timely and quality primary care could improve our nation’s health, but no amount of health care can remedy social disparities in health. Health reform that makes health equity a goal demands a bolder agenda that acts on the social, economic, environmental, and political factors—or “social determinants

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1. Andrea Sisko et al., Health Spending Projections Through 2018: Recession Effects Add Uncertainty to the Outlook, 28 Health Aff. w346, w347 (2009), http://content.healthaffairs.org/content/28/2/w346.full.pdf.


of health”—implicated in the disproportionate incidence of disease and premature mortality among poor and minority groups.5

While other countries have pioneered promising national health equity initiatives from which the United States might learn, the prospect of a comprehensive, government-led agenda faces significant barriers. They include an idea with a long history in this nation—personal responsibility for health.6 It is thus notable that the language of “shared responsibility for health” has increasingly found its way into the American vernacular, and at the highest levels of government. President Barack Obama and Secretary of Health and Human Services Kathleen Sebelius, among others, have declared health a collaborative enterprise.7 In this Article, I take up the question of why health should be treated as a shared responsibility, what that entails for the subjects of responsibility, and what shared responsibility might look like in practice. I will propose a notion of shared responsibility for health that takes seriously the social determinants of health, yet also underscores the role for individual agency, and use it to evaluate a range of health reform and health promotion activities proposed or underway in the United States. I will begin with a brief description of the nature and extent of U.S. health disparities and the notable efforts of the United Kingdom and Canada to promote health equity as a policy goal around the world and in their respective populations.

II. BACKGROUND

The U.S. population’s health has improved markedly in the last one hundred years. People live substantially longer—from forty-seven years in 1900 to seventy-seven years in 2000—and report feeling significantly healthier throughout their later years.8 These gains in health, however, have not been shared equally among all groups. Public health research

7. See Robert Pear, Obama Open to Mandate That People Own Coverage, N.Y. TIMES, June 4, 2009, at A17 (quoting President Obama being open to proposals for “shared responsibility” in health care); Interview by Wolf Blitzer with Kathleen Sebelius, Sec’y of Health & Human Servs., in CNN Studio (July 12, 2009), http://archives.cnn.com/TRANSCRIPTS/0907/12/sotu.01.html (Secretary Sebelius arguing that Americans “have a shared responsibility” to pay for healthcare reform).
has documented significant and enduring social inequalities in health within the United States, and these inequalities are growing.9

Studies show disparities by social class, race and ethnicity, and geographic region. For example: a blue-collar worker is 2.3 times more likely to die from a heart condition than a businessman;10 African American males in the District of Columbia have a life expectancy 17 years less than a white male in Montgomery County, Maryland;11 and males in southwest South Dakota have a life expectancy 22.5 years less than females in Stearns County, Minnesota.12 Some regional groups have experienced absolute declines in health, as illustrated by the decline in life expectancy between 1982 and 2001 among low-income white women in Appalachia and the Mississippi Valley.13

In addition to these intra-country disparities, America’s health fares poorly relative to other countries. In 2004, the United States ranked forty-sixth in average life expectancy from birth and forty-second in infant mortality among 192 nations.14 The United States also fares poorly in terms of morbidity. For example, a 2006 study that compared morbidity among older individuals in the United Kingdom and the United States concluded that “[U.S.] residents are much less healthy than their English counterparts and these differences exist at all points of the [socioeconomic] distribution.”15

Health care reform that guarantees all Americans access to timely and quality primary care could improve our nation’s health16 and help reduce inequalities in health status.17 But health care is not the primary determinant of health.18 Reforms that aim to produce a more equitable

12. Murray et al., supra note 3, at 1514.
13. Id. at 1519.
17. See Barbara Starfield et al., Contribution of Primary Health Care to Health Systems and Health, 83 MILBANK Q. 457, 471 (“Thus, the U.S. studies showed that an adequate supply of primary care physicians reduced disparities in health across racial and socioeconomic groups.”).
18. See Richard Wilkinson & Michael Marmot, Introduction to REG’L OFFICE FOR EUR.,
distribution of health must act on the root causes, or “social determinants” of health.19

Such initiatives have grown in number and scale over the past decade. The World Health Organization’s (“WHO”) Commission on Social Determinants of Health identifies numerous initiatives from high-, middle-, and low-income countries advancing health equity agendas.20 A recent review of health equity efforts throughout Europe describes reforms implemented in the United Kingdom as the most advanced for their degree of comprehension and coordination across policy sectors.21 That nation’s process began with the landmark Black Report on health inequalities, commissioned by the Labour government in 1977 and reluctantly published by the Conservative government in 1980.22 Although the Black Report spurred action in countries such as the Netherlands and Italy long before gaining traction in the United Kingdom,23 the government-commissioned Acheson Report published in 1998 set into motion a ground-breaking series of initiatives. The report proposed both new policies for reducing health inequalities and the assessment of existing policies in non-health sectors for their impact on health inequalities.24 Current U.K. policies range from those focused on reducing childhood poverty and investing in early childhood development to health action zones that aim to reduce poverty in deeply deprived areas to tax credits for working families.25 Furthermore, disparity reductions goals have been set for 2010.26

Canada’s efforts are also noteworthy, in part for their early beginnings. A 1974 report from then Canadian health minister Marc

supra note 5, at 7.

19. See id. at 7, 9.


23. See Mackenbach & Bakker, supra note 21, at 1409.


25. See Exworthy et al., supra note 22, at 1911-12.

26. Mary Shaw et al., Health Inequalities and New Labour: How the Promises Compare with Real Progress, 330 BRIT. MED. J. 1016, 1016 (2005) (stating that in 2001, the Labour Party announced its goals “to reduce the gap in infant mortality across social groups and to raise life expectancy in the most disadvantaged areas faster than elsewhere”).
Lalonde criticized the focus on health care delivery as a means to promote health and called for the development of a conceptual framework that addressed the non-medical health determinants. Although criticized for failing to adequately address the impact of environment on lifestyle and for unleashing a focus on individual responsibility for health, the report became the first in a long series of documents and initiatives to promote health for all Canadians. Not until 1986, however, did Canada publish a document that embodied principles and policies that took seriously the social determinants of health. *Achieving Health for All: A Framework for Health Promotion*, developed alongside the WHO’s *Ottawa Charter*, frames the pursuit of health equity as a societal responsibility and addresses both institutional and environmental determinants of health. Canada has continued to produce high-level policy documents addressing health equity and has restructured data collection and health research to address health equity and the non-medical determinants of health.

Recent reviews of both countries’ efforts nonetheless identify serious challenges. In the United Kingdom, pitfalls include limited evidence about effective interventions and change in intermediate outcomes, poor integration of health inequality initiatives into mainstream systems, and the government’s rejection of income redistribution through taxation as a remedial strategy. Canadian initiatives have failed to penetrate across government sectors due to a lack of research that could inform policy tradeoffs among sectors and to the fact that policy officials in the finance sector found the non-medical determinants of health message unpersuasive.

The respective achievements and challenges of the United Kingdom and Canada may be attributed to any number of forces, but public values

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29. See *Achieving Health for All: A Framework for Health Promotion*, supra note 27 at 133.


31. See Exworthy et al., supra note 22, at 1916-17.

32. See *Exworthy et al.*, supra note 22, at 1917-18.

33. See Shaw et al., supra note 26, at 1020.

34. Lavis, supra note 30, at 109.

35. *Id.* at 110-11.

36. *Id.* at 110.
are clearly at work. The values held by policy makers and polities influence which social issues become defined as problems, how those problems are framed, and whether they are acted on. It is significant that their official documents and initiatives cast health inequalities as “inequities” or “disparities,” which connote their moral unacceptability, and justify government action on grounds of social justice and social responsibility. The theme of personal responsibility for health has not been absent in these political contexts, but it appears not to have dominated health promotion and disease prevention policy.

The same cannot be said for the United States. Personal responsibility is a core American value and its prominence in the context of health has a long history. Over the past few decades the health responsibility debate has intensified and within political discourse often plays out in predictable and unproductive terms. In its barest form, proponents of personal responsibility deny any role for structure in health and proponents of social responsibility downplay the role of

37. See Exworthy et al., supra note 22, at 1916 (citing John W. Kingdon, Agendas, Alternatives, and Public Policies 172-79 (2d ed. 1995)) (explaining Kingdon’s model of policy-making, in which issues get put on the agenda based on the confluence of three “streams”: problems, policies, and politics); see also David Mechanic & Jennifer Tanner, Vulnerable People, Groups, and Populations: Societal View, 26 Health Aff. 1220, 1221-22 (2007), available at http://content.healthaffairs.org/content/26/5/1220.full.pdf (arguing that morals affect how society views the vulnerable and thus whether or not it will provide public assistance).


39. See, e.g., Minkler, supra note 28, at 133 (explaining that while Canadian health policy shifted away from a “individual responsibility” focus, it still encouraged “[s]elf-care” by advocating for the creation of “healthy environments” where “positive personal behaviors could flourish”); Shaw et al., supra note 26, at 1016 (“In 1997 [the British minister for public health] . . . criticised the previous administration for its ‘excessive emphasis on lifestyle issues’ that ‘cast the responsibility back onto the individual.’”).

40. See Reiser, supra note 6, at 7-9 (examining the history of beliefs regarding “the role of human choice in determining and controlling personal health”).

41. This debate has not, however, played out in predictable ways within moral philosophy. As philosopher Dan Wikler explains, generally left-leaning philosophers have developed responsibility-sensitive theories of egalitarian justice whose implications for health policy fall far to the right of those typically proposed by political conservatives. See Dan Wikler, Personal and Social Responsibility for Health, in PUBLIC HEALTH, ETHICS, AND EQUITY 109, 118-24 (Sudhir Anand et al. eds., 2004).

health-related behaviors in poor health. This debate, long deemed a straw man by some, has begun to give way to calls for integrating “the role of the individual” into the social determinants of health paradigm. This debate, which I treat in Part III, will set the stage for exploring the meaning and implications of a commitment to share responsibility for health.

III. SHARING RESPONSIBILITY FOR HEALTH IN THE U.S. CONTEXT

Mounting evidence of the contribution of personal behaviors to chronic disease and the increasing incidence of such diseases has intensified the debate over health responsibility. That debate has generated a number of helpful analyses that illuminate the meaning of health responsibility and its many implications for health policy. An analysis by Harald Schmidt reveals considerable variation in the concept’s meaning, though three senses of responsibility are thematic. Role responsibility refers to those actions that follow from personal identity and role, which in the context of health can simply refer to the fact that a person should take better care of herself because only she can. Causal responsibility refers to the contribution an individual’s behaviors make to health outcomes. And, liability responsibility refers to the idea that individuals should be held liable for the adverse consequences of their voluntary health-related actions.

Causal and liability responsibility figure pivotally in personal responsibility proposals. For example, recommendations to lower the treatment priority of individuals, whose disease is deemed the product of free choice, or for disease prevention programs to target only those diseases deemed not the product of free choice turn on a view that people who freely cause their poor health should be held accountable for

43. See, e.g., Wikler, supra note 41, at 123 (“P]ersonal responsibility for health deserves . . . a peripheral role in health policy.”).
44. See Minkler, supra note 28, at 126 (“Few, if any, health educators or health psychologists would argue that individuals lack any responsibility for health-related decisions and actions, making the question of individual versus social responsibility something of a straw man in these circles.”).
46. See generally Gerald Dworkin, Taking Risks, Assessing Responsibility, HASTINGS CENTER REP., Oct. 1981, at 26 (examining various theories of responsibility, and how it relates to the formation of health policy); Wikler, supra note 41 (discussing various philosophies regarding personal responsibility and their relation to forming health policy).
47. See H. Schmidt, Just Health Responsibility, 35 J. MED. ETHICS 21, 22-23 (2009).
48. See Dworkin, supra note 46, at 27, 29.
50. Id.
it in some way. Although such proposals can be rejected on a number of
grounds,51 much of the rebuttal has attempted to establish the primacy of
social structure in the production of health and thus diminish the role of
individual agency.52

To that end, rebuttals can draw on ample epidemiological data
establishing social factors as causes of illness to make at least two sorts
of arguments. First, social conditions can exert health-harming
properties regardless of individual behavior, as evidenced by studies
showing that significant health differences between advantaged and
disadvantaged groups remain after controlling for behaviors related to
diet, exercise, and smoking.53 Thus it can be shown that contexts, such
as poor neighborhoods, are associated with different risk profiles that
harm health independently of any behavior directly associated with
health.

Second, social conditions can directly shape health behaviors. Explana-
tions of the disproportionate incidence of poor health behaviors
exhibited by low income groups may be used to argue that a low
socioeconomic position truncates the range of health-promoting options
available to these groups54 or that it otherwise impinges individual
agency by limiting opportunities for control over health-consequential
circumstances55 by undermining the development and exercise of health-
related agency,56 or by rendering people “victims” of their
environment.57 Furthermore, explanations of the better health of more
advantaged groups may be used to argue that individuals use their

51. See, e.g., id. at 18 (arguing that “the causal relationship between . . . risk-taking behavior
and the financial status of others is often difficult to make out”); id. at 19 (arguing that allowing
freedom of choice often involves making choices which will burden others); id. at 21 (arguing that
personal responsibility tends to focus on personal behavior—such as “smoking, sloth, and [being]
overweight”—that seem to be a matter of personal choice, but are “notoriously difficult to give
up”).

52. See id. at 21-23 (stating that those who claim that unhealthy habits are the result of social
determinants emphasize the role of social structure, and sometimes “dismiss the possibility that
those with unhealthy habits had any real choice”).

53. See Paula M. Lantz et al., Socioeconomic Factors, Health Behaviors, and Mortality: Results
from a Nationally Representative Prospective Study of US Adults, 229 J. AM. MED. ASS’N 1703, 1706-07

54. See Wikler, supra note 49, at 22-24 (arguing that poor health habits of disadvantaged
groups can be understood as the result of a lack of any meaningful choice).

55. See S. Leonard Syme, Social and Economic Disparities in Health: Thoughts About

56. See Erika Blacksher, On Being Poor and Feeling Poor: Low Socioeconomic Status and
the Moral Self, 23 THEORETICAL MED. & BIOETHICS 455, 460-67 (2002).

57. See Robert Crawford, You Are Dangerous to Your Health: The Ideology and Politics of
Victim Blaming, 7 INT’L J. HEALTH SERVICES 663, 671, 675 (1977) (arguing that a philosophy
which emphasizes personal responsibility for health without taking into account the socioeconomic
circumstances that influence personal choices is “victim blaming”).
socioeconomic resources—money, knowledge, power, prestige, and social support—to protect their health and to minimize the consequences of injury and disease.  

For example, Bruce G. Link and Jo C. Phelan frame the resources that shape health behavior and access to contexts with different risk profiles as “fundamental” causes of disease because they exert their causal properties reliably over time, even as diseases, treatments, and health risks change dramatically from one historical period to the next.  

They argue that as humanity exerts more and more control over disease, advantaged groups become better-situated to protect and promote their health and thus generate new disparities in health.  

None of these arguments removes the individual from the scene, but each attempts to relocate responsibility for poor health from the individual to some form of social structure or process. “The locus of blame is key, for if blame is placed on the individual, social structure is exculpated, and the resulting suffering and premature death will not be counted as a social injustice.” This view taps the moral intuition that justice demands the remedy of inequalities (in health or other important goods) generated by unjust social institutions and policies, and provides moral support for exhortations to identify and remedy the “causes of the causes” of poor health or the conditions that “put people at risk of risks.”  

Friends of health equity have nonetheless expressed concerns about an agenda oriented exclusively toward structural reforms. For example, noting the shift toward a broad and integrative epidemiology that resists binary models, Ian Forde and Rosalind Raine point out the artifice of trying to disentangle social and individual factors of health, and the contention that dogs efforts to prove the primacy of either. They argue that “the causes of the causes cannot, and so should not, be separated from the causes of poor health.”

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60. See Link, supra note 8, at 373-74; Link & Phelan, supra note 59, at 730.
61. Wikler, supra note 41, at 115.
63. COMM’N ON SOC. DETERMINANTS OF HEALTH, supra note 11, at 42.
64. Link & Phelan, supra note 58, at 85.
65. Forde & Raine, supra note 45, at 1694.
66. Id.
The fact is that individual attributes make a non-trivial contribution to health, can be identified, and can be modified. Indeed, they often must be modified in order for structural interventions to have their intended effect. Although the health benefits of some structural reforms are virtually unavoidable (e.g., as when public sources of water are fluoridated or automobile airbags mandated) and thereby nearly universal in their impact regardless of personal effort or resources, many population-based interventions do not so seamlessly translate into health improvements at the individual level. Many interventions still require individuals to take action and thus are subject to some of the same barriers that limit the uptake of more individualistic health interventions, especially among socially-disadvantaged groups. Just as cultural beliefs, low-income, low-educational attainment, chronic socioeconomic stress, or fatalist attitudes may impede one from acting on information about health risks—these same attributes may work to erode the benefits of a population-based intervention, such as a smoking ban.

The implication here is not only that population-based measures may be less effective than they could be, but that they, like their more individualistic counterparts, may generate health disparities. Even if the maldistributive potential of population-based interventions is less than that of individualistic interventions—a question that depends in part on how one defines equity—the concern about socioeconomic constraints on health agency stands. This interaction between individual and structural factors supports the case for a health strategy that contains both interventions that improve health, independent of individual effort and socioeconomic level, and those that provide education and training

67. See id. at 1694-96.
70. See Frohlich & Potvin, supra note 68, at 285.
71. See Frohlich & Potvin, supra note 68, at 285.
72. See Frohlich & Potvin, supra note 69, at 219.
73. Health interventions may raise the absolute level of health of disadvantaged groups even as they exacerbate inequalities between better- and worse-off groups. See id. No consensus exists as to whether health equity should be defined in terms of achieving an absolute minimum of health, equality per se, or some other relational ideal. See MADISON POWERS & RUTH FADEN, SOCIAL JUSTICE: THE MORAL FOUNDATIONS OF PUBLIC HEALTH AND HEALTH POLICY ch. 3 (2006) (discussing disagreements between various theories of equity).
74. See Bruce G. Link & Jo C. Phelan, Fundamental Sources of Health Inequalities, in POLICY CHALLENGES IN MODERN HEALTH CARE 71, 72, 78-80 (David Mechanic et al. eds., 2006)
programs that enhance individuals’ skills and capacities for acting on the life- and health-enhancing opportunities that structural reforms make available.\textsuperscript{75}

Moreover, an exclusive focus on the structural determinants of health may not only forgo the constructive potential of individual agency, it may telegraph a negative message about the agency of those who bear the brunt of disease. A health promotion agenda which casts those with poor health as victims of their circumstances or unable to make positive life changes risks further undermining or perhaps stigmatizing those already marginalized by race, ethnicity, poverty, or other markers of disadvantage.\textsuperscript{76}

If structure and agency are both implicated in the production of health, and if the pursuit of health equity could be enhanced by a strategy that attends to both, how should the health responsibility debate be framed? Health should be understood as a shared responsibility. The phrase might seem to dilute accountability, but the language of \textit{responsibility} requires that we get specific about actors and their obligations. We have to ask, “Who is responsible for what action toward whom and on what normative grounds?”\textsuperscript{77}

So, in the pursuit of health equity, who are the subjects of responsibility and what are they obligated to do? The question is best answered in the context of ground-level knowledge of the populations of interest, barriers to health, and the resources and opportunities available within particular social and political contexts. But as a general response to the question, two sets of actors and actions can be identified.

One set of actors—call them agents of population health—includes bodies of collective action that can work effectively to create the social, material, and environmental conditions for health. The recent report from WHO’s Commission on the Social Determinants of Health identified a list of such bodies that includes global institutions and agencies, national and local governments, civil society, research and

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\textsuperscript{75}. See Komla Tsey, \textit{The Control Factor: A Neglected Social Determinant of Health}, 372 LANCET 1629, 1629 (2008) (arguing that intervention programs which educates people about health matters is desirable, but that it is useless if the individuals being taught do not have the capacity to learn).

\textsuperscript{76}. See Crawford, \textit{supra} note 57, at 675 (“A deterministic view which argues that individuals have no choice should be avoided.”); Bruce G. Link & Jo C. Phelan, On Stigma and Its Public Health Implications (Sept. 6, 2001) (unpublished manuscript), http://www.stigmaconference.nih.gov/FinalLinkPaper.html (explaining how stigmas can negatively affect the psyche of labeled persons “in important ways that do not involve obvious forms of discriminatory behavior”).

\textsuperscript{77}. See Schmidt, \textit{supra} note 47, at 23.
academic communities, and the private sector.\(^{78}\) What, in the name of health equity, should they do? The WHO report details various categories of action, many of which can also be found in the recommendations of other documents and commissions who have addressed the social determinants of health, including the national initiatives already described. They include investing in children’s development and health, creating communities and work places that promote physical and psychological health, and securing social protection and universal health care across the life course.\(^{79}\) These categories of action also include other activities aimed at achieving a more equitable distribution of resources such as gender equity, market responsibility, and the political empowerment of marginalized groups.\(^{80}\) The overarching responsibility is to create fair conditions and opportunities for a healthy life and normal lifespan.

Noting the powerful and entrenched interests arrayed against this goal, others have underscored the necessity of another, less official, form of collective action—the political struggle that historically has been the product of social movements.\(^{81}\) This important reminder about how social change happens—from and by the people whose interests are most dearly at stake—points to a second set of actors implicated in the project of health equity. Individuals who are sick, at risk of illness, or otherwise the targets of health promotion and health equity reforms also have responsibility, though not the sort associated with bare-knuckled calls for personal responsibility.

Schmidt’s conception of “co-responsibility” goes some distance in describing the responsibility that might apply to vulnerable groups. Recognizing that personal control over health admits of degrees, Schmidt proposes a “more nuanced and less punitive” notion that assigns responsibility yet withholds blame.\(^{82}\) This conception prohibits punishments such as higher premiums for illness or lower priority for treatment of illnesses to which individual behaviors contribute, and endorses more positive strategies such as health education programs and

\(^{78}\) Comm’n on Soc. Determinants of Health, supra note 11, at 44-45.
\(^{79}\) Id. at 4, 6-7, 9-10.
\(^{80}\) Id. at 10, 14-16, 18.
\(^{81}\) See generally Anne-Emanuelle Birn, Making it Politic(al): Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health, 4 Soc. Med. 166 (2009) (critiquing the Commission’s report for not taking political struggles into account); Vicente Navarro, What We Mean By Social Determinants of Health, 39 Int’l J. Health Services 423 (2009) (arguing that changes in social determinants of health are the result of political struggles, and critiquing the Commission’s report as being “profoundly apolitical”).
\(^{82}\) Schmidt, supra note 47, at 24-25.
campaigns that raise individuals’ awareness and capacity for positive change.\(^{83}\)

Fine as far as it goes, this conception of responsibility overlooks a form of action particularly relevant in the context of health equity. Where universal policies cannot be implemented and targeting must apply, communities and populations of interest should be treated as “full partners” and “peers” in the project of better health.\(^{84}\) Their knowledge and input should be sought out, participation recruited, and home-grown interventions supported.\(^{85}\) In this, agents’ capacity for positive change potentially expands from their own health to that of their communities and perhaps to larger social units.\(^{86}\) Public health and development experts have long recognized that recruiting community members as agents of change can leverage the empowerment potential of such initiatives and improve their effectiveness.\(^{87}\) It may also cultivate respect and recognition among parties.

With this notion of shared responsibility in mind, we can ask this paper’s last question: how do health promotion experiments proposed or underway in United States fit the bill? The current ferment in health reform and health promotion activities reveals signs of progress and stubborn tendencies. I begin by looking at two policy experiments, one underway and one proposed, that reveal regressive tendencies and conclude on a note of measured optimism, describing a number of initiatives that suggest a shift in the right direction.

### A. West Virginia Medicaid Reform and the Safeway “Wellness” Amendment

Made possible by the 2005 Deficit Reduction Act that gave states new options for reducing Medicaid benefits, West Virginia in 2006

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\(^{83}\) See id.

\(^{84}\) This is the language of political theorist Nancy Fraser who argues that social justice requires not simply fair distribution but recognition. See Nancy Fraser, *Rethinking Recognition*, NEW LEFT REV., May–June 2000, at 107, 113-14.

\(^{85}\) See id. at 115 (“[R]edressing misrecognition means replacing institutionalized value patterns that impede . . . participation with ones that enable or foster it.”).

\(^{86}\) See Ross C. Brownson et al., *Demonstration Projects in Community-Based Prevention*, J. PUB. HEALTH MGMT. & PRAC., Mar. 1998, at 66, 67 (explaining that the “use of coalitions or consortia” can positively impact the health of a community in ways “beyond the influence of any single individual or organization”).

implemented a plan in which benefits vary depending on client behavior. An “enhanced” package of services is reserved for clients who sign a contract (on behalf of themselves and their children if they have them) in which they agree to undergo screening exams, follow the doctor’s prescribed regimen, show up on time for appointments, and otherwise try to stay healthy. Failure to meet expectations relegates clients and their children to a ‘basic’ plan that excludes benefits that were once standard. Children in the basic plan are no longer eligible for skilled nursing care, prosthetics, nutrition education, diabetes care, and mental health services, among other services. Parents in the basic plan face similar restrictions.

The demerits of the plan are numerous and have been well chronicled. Three speak to this paper’s interests. First, the plan makes no attempt to alter the social conditions that influence clients’ ability to adopt healthier behaviors or the contexts in which they live and work. Second, the plan structure is punitive, eliminating essential services, even those such as nutrition education that could enhance clients’ knowledge and capacity for health. Finally, the plan went into place with no opportunity for public input or comment. Not surprisingly, analysts suggest the plan will worsen, not improve, the health of those subject to these policies.

A proposed amendment in the Senate health care reform bill, known as the Safeway Amendment, is less draconian but fails on similar grounds. The amendment expands existing rules for workplace wellness programs that offer incentives, including premium discounts for participation in health promotion programs and attainment of weight-, cholesterol-, and tobacco-related goals. Currently, most wellness

89. Id. at 1, 3.
90. Id. at 3.
91. Id. at 2.
92. Id. at 3.
94. See Bishop & Brodkey, supra note 93, at 757.
95. See SOLOMON, supra note 88, at 2-3.
96. Id. at 1.
97. See, e.g., id. at 4-5.
98. See Harald Schmidt et al., Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives, 362 NEW ENG. J. MED. c3(1), e3(1)-e(2) (2010), http://www.nejm.org/doi/pdf/
programs refrain from punitive measures and instead encourage healthy habits by offering employees helpful resources (for example, on-site fitness centers and online meal planning guidance) and relatively small rewards (for example, coupons and prizes) for meeting behavioral and/or biomarker goals. Analysts have shown that as amended by the Senate bill, the rules for these programs allow for potentially significant cost increases for employees who fail to meet goals. Given the social gradient in health behaviors and the difficulty of making behavior change, the plan is likely to penalize employees on the low end of the pay scale “who are generally less healthy than their higher-paid counterparts and thus in greater need of health care, less likely to meet the targets, and least likely to be able to afford higher costs.”

B. Promising Activities

Forces for a progressive health agenda have been gathering strength in the last decade. Institutes dedicated to health equity, health promotion, and community development have been established; national commissions and bodies have issued reports on health disparities and the social determinants of health; states and communities have begun to invest in and transform their communities, and proposed

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99. Exceptions include Scotts Miracle Gro Company’s program that—while offering a rich set of tools to improve health behaviors, such as an on-site clinic, fitness center, and personal health coaches—exacts heavy penalties for not complying with the plan, including firing employees for smoking, on or off site. A lawsuit is pending in Massachusetts. See Blacksher, supra note 93, at 13 (describing the anti-smoking program and the pending lawsuit); Michelle Conlin, Get Healthy—Or Else: Inside One Company’s All-Out Attack on Medical Costs, BUS. WK., Feb. 26, 2007, at 58, 60, 63-64 (describing Scotts’ health program, as well as the circumstances surrounding the lawsuit).
100. See Blacksher, supra note 93, at 13.
103. See, e.g., NAT’L P’SHP FOR ACTION TO END HEALTH DISPARITIES, supra note 104 at 3, 5 (stating that since 1985, “a large number of minority health-related programs” have come into existence, but that they are often an “inadequately tapped resource”).
Congressional health reforms include some enlightened recommendations.106 The five activities described below represent national, state, and local initiatives that signal progress.

The Robert Wood Johnson Foundation’s (“RWJF”) Commission to Build a Healthier America published a report in early 2008 that laid out the case for the social determinants of health.107 Although the report was neither government-commissioned—as was the U.K.’s Black and Acheson reports—it was the first commission of its kind in the United States and the product of bipartisan commissioners.108

RWJF and The Pew Charitable Trusts have established a national initiative to promote policy makers’ use of Health Impact Assessments (“HIAs”) that identify the health consequences of policies in non-health sectors.109 The philanthropies created a national center of excellence to coordinate the effort, fund demonstration projects, provide training and technical assistance, and conduct two federal-level HIAs.110 HIAs enable the kind of inter-sectoral government action endorsed by the U.K.’s Acheson Commission and WHO’s Commission on the Social Determinants of Health and generate data necessary for evidence-based decision making across policy sectors.111

Health reform legislation contains considerable dollars directed at prevention, including community transformation grants to fund infrastructure changes that facilitate healthier living, such as walking and biking paths, lighted sidewalks and playgrounds, and farmers’ markets112 and a defined benefit package that waives cost-sharing for basic preventive services and well-baby and well-child visits,113 among many other efforts to elevate and empower the voice of public health.

106. See, e.g., Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 4201 (2009) (setting up community transformation grants for health-based infrastructure projects); Affordable Healthcare for America Act, H.R. 3962, 111th Cong. § 222(c)(1) (2009) (setting up a basic health care package which waives cost-sharing for basic child care services).

107. See BRAVEMAN & EGERTER, supra note 104, at 11 (explaining existing disparities in health based on social determinants such as race and class).


110. Id.

111. See id. (“HIAs use a flexible, data-driven approach that identifies the health consequences of new policies and develops practical strategies to enhance their health benefits and minimize adverse effects.”); see also COMM’N ON SOC. DETERMINANTS OF HEALTH, supra note 11, at 45 (arguing that “intersectoral collaboration” is critical for actions on social determinants of health); DEP’T OF HEALTH, supra note 24, at 139-40 (listing Acheson inquiry recommendations calling for local and national governments to act together on health inequalities).

112. See Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 4201 (2009).

As early as 2001, Minnesota’s Department of Health published *A Call to Action: Advancing Health for All Through Social and Economic Change* that outlined a social determinants of health framework for promoting Minnesotans’ health.\(^{114}\) This report was one among several factors that influenced the Blue Cross Blue Shield of Minnesota Foundation’s development of projects to improve the social and economic conditions of vulnerable communities as a means of reducing health disparities in the state.\(^ {115}\) Its “Growing Up Healthy” grants support place-based collaborations across Minnesota that improve access to safe, healthy, affordable housing; early learning; and clean neighborhoods.\(^ {116}\) Investing in children’s development is the signal activity endorsed by WHO’s Commission on the Social Determinants of Health, U.K.’s Acheson Commission, and RWJF’s Commission to Build a Healthier America, and is a policy recommendation that has garnered bipartisan support in the United States.\(^ {117}\)

Under the leadership of Mayor Michael Bloomberg and public health commissioner Thomas Freiden (now director of the Centers for Disease Control), New York City instituted an array of policies and initiatives to promote health in New York City’s neighborhoods, from requiring restaurants to post calorie counts, to banning trans fats in public restaurants, to planting trees in low-income, high-asthma neighborhoods.\(^ {118}\) The city’s plan to plant a million trees over a decade


\(^{117}.\) See BRAVEMAN & EGERTER, supra note 104, at 68 (listing suggested solutions to health inequalities, three of which involve child development); COMM’N ON SOC. DETERMINANTS OF HEALTH, supra note 11, at 3-4 (enumerating solutions for child development issues); DEP’T OF HEALTH, supra note 24, at 137-38 (listing Acheson Inquiry’s recommendations for children’s health issues); Gail R. Wilensky & David Satcher, *Don’t Forget About the Social Determinants of Health*, 28 HEALTH AFF. w194, w195 (2009), http://content.healthaffairs.org/ content/28/2/w194.full.pdf (arguing that improving health based on social determinants of health can gain bipartisan support in the United States, and doing so is especially important for children).

\(^{118}.\) See 24 R.C.N.Y. § 81.08 (2008) (restricting sale of foods containing trans fats); 24 R.C.N.Y. § 81.50 (2008) (requiring restaurants to show calorie content of meals on menu board and menus that are made publicly available); Press Release, MillionTreesNYC, Mayor Bloomberg and Agriculture Secretary Vilsack Announce $2 Million Federal Grant to Create Green Jobs as Part of MillionTreesNYC Campaign (Apr. 8, 2009), available at http://www.milliontreesnyc.org/
to create shade and beauty and to cleanse and filter neighborhood air, is notable for creating jobs for at-risk teens and young adults.\textsuperscript{119} Some twenty young adults, ages sixteen to twenty-five, have been employed at twelve dollars an hour to learn about horticulture, plant, and care for trees.\textsuperscript{120}

In different ways, these activities express a commitment to sharing responsibility for health. They aim to create environments that enable and support healthful living and to collaborate with individuals as agents of change in their own lives and their communities. I have also noted, where appropriate, when these initiatives might have appeal across the political spectrum, an important practical consideration in a political context as polarized as the United States. A Congress splintered among left-leaning Democrats who deem the proposed health care reforms too conservative, right-leaning Democrats who declare them too liberal, and right-wing Republicans who condemn them as “socialist,” stands as a sharp reminder of the challenge that lies ahead. The pursuit of a truly comprehensive health equity agenda will require more than the official actions of commissions, institutions, researchers, policy leaders, and civic organizations. It will require the political commitment, and struggle, of ordinary Americans.

\textsuperscript{119} Press Release, MillionTreesNYC, supra note 118.

\textsuperscript{120} Arun Venugopal, \textit{City to Train Young to Plant Trees}, WNYC (Apr. 8, 2009), http://www.wnyc.org/articles/wnyc-news/2009/apr/08/city-to-train-young-to-plant-trees/.