
Health, Health Care, and the Contraception Requirement

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1. Introduction

The Patient Protection and Affordable Care Act (PPACA) includes the provision that employer-based health insurance plans be required to cover contraceptives for their enrollees without cost-sharing. A common reaction to this provision in public discourse is that contraception is not health care, so private insurance plans should not be mandated to cover it, nor should publicly subsidized insurance plans pay for it. One frequently given reason for this position is that unwanted pregnancy is not a disease or disability.1 On the other side of the debate, defenders of the contraception requirement in the PPACA argued that in many cases pregnancy carries significant health risks so contraception can be understood as a kind of preventive care. In addition, some kinds of hormonal birth control offer health benefits for patients taking it, such as the reduction of dysmenorrhea, lessening of acne, or the prevention of ovarian cysts.2

The primary goal of my paper is to offer two arguments in defense of the contraception requirement. The first has to do with the definition of health, and the second has to do with the goals of health care.

The first way to defend the contraception requirement is to show that health can be more broadly understood than merely as the prevention or cure of disease and disability. Critics of the contraception requirement typically claim that pregnancy is not a disease or disability, so its prevention is thus not a part of maintaining health. This argument assumes the biomedical model of health and disease, which is seriously flawed. If we adopt an alternative account of health, such as Lennart Nodenfelt’s holistic model, the typical arguments against the contraception requirement do not work.3

2. THE BIOMEDICAL MODEL VS. THE HOLISTIC MODEL OF HEALTH

Consider Christopher Boorse’s definition of health, which is one of, if not the most influential statement of the biomedical model of health. According to Boorse, very briefly, health is both “statistical normality of function” relative to age and sex, and the absence of disease.4 On this view, “diseases are internal states that depress a functional ability below species-typical levels.”5 The key functional abilities that Boorse uses to measure disease are survival and reproduction.6 Boorse argues that biology can tell us what constitutes normal functioning by understanding how our ‘bodies’ various functions contribute to our survival as a species.7

There are at least three kinds of criticism of Boorse’s biomedical model. First is the worry that it does not capture the phenomenology of illness. In Havi Carel’s words, it does not include the “lived experience” of health and illness.8 On her view, going from being healthy to being sick involves substantial changes in personal agency and the way one interacts with one’s social and physical world.9

Second is the normativist or constructivist critique, that the biomedical model falsely assumes that a definition of health can be free of normative elements.10 Specifically, notions of health and disease cannot escape being infused with value judgments that are far from being objective or even universally accepted. Instead, they are “sociological, culturally determined value judgments.”11 For example, disability theorists have criticized Boorse’s notion of normal function on the grounds that disability is “a social construction” rather than a “biological deficiency.”12 Normativists often point to the history of medicine, which is rife with examples of the medicalization of social, moral, or political acts, such as the characterization of masturbation, sexual desire (or lack thereof) in women, or the tendency in slaves to try to run away, as diseases.13

The third criticism is that Boorse’s reliance on evolutionary theory and adaptation is misapplied or problematic.14 For example, on Boorse’s account, homosexuality may count as a disease, or a state of unhealth, since it is not statistically normal and it seems to hinder reproduction.15

Since Boorse’s biomedical model of health and disease has serious flaws, including narrowness, alternatives should at least be considered. The danger of constructing a broader notion of health is that it might end up including too much. For example, the World Health Organization’s definition of health is “a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.”16 This definition has been widely criticized for being vague and practically unusable.17 One of its most problematic elements is that it seems to confl ate health and happiness, which are two distinct (albeit related) states.18

But even if health can be more broadly understood than the absence of illness and disease, the best conception of health might still not have room for the contraception requirement in the relevant way. Assuming that the woman’s reason

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for using contraception is to prevent pregnancy, it might make sense to say that some minimal level of control of if and when one becomes pregnant is part of being healthy. Certainly health does not include complete autonomy over one’s reproductive capabilities. We would not want to say that an eighty-year-old woman, who is unable to conceive, though she wants to, is unhealthy on those grounds. Nor would we endorse the broader claim that part of health is control over all of one’s bodily functions. The fact that I cannot exert complete control over my resting heart rate does not make me unhealthy. On the other hand, if one has little to no control over when one urinates (incontinence), on many accounts this would constitute ill health.19

Nordenfelt’s holistic theory comes close to meeting both of these standards for a definition of health. It isn’t too broad and yet it can accommodate the idea that health includes a certain level of control over one’s body. According to Nordenfelt:

A is completely healthy if, and only if, the organic structure of A is such that it enables A to achieve all his or her vital goals, given standard circumstances.20

A person’s vital or essential goals are the goals which “are of especial importance for the person” to achieve or maintain.21 Without realization of one’s vital goals, “a person’s satisfaction with life will be affected.”22 The goals include, but are not limited to survival, reproduction, the preservation of family ties, maintaining current residence, remaining employed, or finding better employment.23 Importantly, according to Nordenfelt, not being able to meet one of a person’s vital goals does not necessarily make that person sick or diseased; instead, it may mean that the person is not in a state of complete health.

Nordenfelt does not explicitly address contraception, but it seems plausible that some level reproductive autonomy could easily be added to his list of vital goals. The goal of being able to stay in one’s own house is surely no more important than the goal of avoiding an unwanted pregnancy. In this way, on Nordenfelt’s view, the inability to control when and if one conceives can be understood as an element of ill health. At least this inability would mean that the person is not in a state of complete health.

Health conceived of as the ability to achieve one’s most important goals faces several objections. One significant objection is that the concept of a “vital goal” is not precise enough, that it captures too many desires.24 A second objection is that Nordenfelt’s account, like the WHO definition, ties health too closely to happiness or that it mischaracterizes happiness.25 There is not time enough in this short paper to discuss Nordenfelt’s and others’ replies to these critiques, or the counter-responses. One promising but preliminary line of response to these difficulties with goal or interest oriented accounts of health involves applying Martha Nussbaum and Amartya Sen’s work on capabilities to the definition of health.26 On a capabilities approach, health is construed as a capability: “the ability to cope with the demands of life, or the ability to exercise key functionings,” whereas what counts as a disease “depend[s] on whether it constitutes a lack of capability for that individual in those circumstances.”27

3. Health Care Beyond the Goal of Health

The second way to defend the contraception requirement is to show that health need not be the sole legitimate aim of health care. Critics of the contraception requirement assume that if pregnancy is not ill health, then it is not within the realm of what health insurance should pay for, namely, health care. In response, I argue that medical professionals have a set of skills and a body of knowledge relating to the human body. They need not only aim at health promotion and restoration. Even Norman Daniels, who endorses the strict biomedical model of health, concedes that health care professionals may aim at other goals. Their skills and knowledge can be used in a variety of ways to satisfy human interests, such as promoting individual autonomy by enabling women (and sometimes their partners) to decide if and when to procreate. It is for this reason that the services of medical professionals might be more aptly referred to as medical care, rather than health care.

One can hold the biomedical model of health and still agree with this claim, as illustrated in Daniels’s work. An important piece of Daniels’s Rawlsian theory of justice and health care is his account of species typical functioning, largely adapted from Boorse’s biomedical model of health and disease. Daniels defines health as “the absence of pathology”; pathology being “any deviation from the natural functional organization of a typical member of the species (or) a departure from normal functioning.”28 Briefly, for Daniels, health is important from the perspective of justice because health problems, which are understood to be deviations from species-typical functioning, diminish equality of opportunity.29

Of course, being pregnant or being at risk of an unwanted pregnancy does not count as a deviation from species-typical functioning. Despite this, Daniels has argued that non-therapeutic abortions should be covered by a national system of health care because doing so is a way of “respect[ing] the equality of women.”30 He writes:

If we are right that nontherapeutic abortion services should be included because of our concerns about the equality of women, then treatment of disease and disability does not capture the class of services we are obliged to provide once we consider all of our obligations.31

Like abortion, contraception does not necessarily prevent, cure, or ameliorate disease. But if funding for non-therapeutic abortions can be justified on the grounds of the equality of women, then so can contraception. In other words, it seems consistent with Daniels’s view to say that medical care can serve other important social goals besides the restoration and maintenance of health.32

A more expansive view of the goals and purpose of health care can be found in Julian Savulescu, who argues that the goals of health care encompass promoting well-being, not just promoting or maintaining health.33 Having a disease or disability is only morally important because it “makes our lives go badly” and can interfere with our ability to do things that we value.34 This means that sometimes health care should involve more than ameliorating disease and bringing people up to a level of species-typical functioning. It may
sometimes require, for example, cognitive enhancement above and beyond what is typical of the species, if this turns out to be an effective and affordable way of promoting well-being. On this view, what we call health care is just a set of tools, institutions, and expertise that can be used to maintain and restore health, prolong life, and relieve pain, as well as achieve other goals. According to this model, it is easy to see why the provision of contraception is part of health care—because it allows women to enhance their quality of life by controlling their reproductive capacities.

4. CONCLUSIONS

Two common assumptions in the debate about the contraception requirement in the PPACA do not hold up to scrutiny. The first assumption is that since unwanted pregnancy is not a disease, contraception cannot contribute to maintaining health. Not only are there significant problems with this conception of health, there are also plausible alternatives to the narrow biomedical model of disease, especially Nordenfelt’s holistic model. Second, even if one does not accept an expanded view of health, one need not see the maintenance and restoration of health as the sole goals of health care. Health care can aim at well-being, autonomy, equality, and even happiness. This clears the ground for a positive argument that the provision of contraceptives should be part of any publically funded health care plan.

BIBLIOGRAPHY


The Right to Health: From Maximization to Adequacy

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I. INTRODUCTION

The International Convention on Social, Economic, and Cultural Rights (ICESCR) defines the right to health as “the right to the enjoyment of the highest attainable standard of physical and mental health.” In a world where so many are so far from this ideal, it is tempting not to investigate the contours of this right too closely. I’ll argue that understanding the right to health as a right to maximum health—to the “highest attainable standard”—is untenable, and we should instead recognize a right to adequate health.

I’ll say some things about the project’s aims up front. My goal is to uncover and highlight problems with our current understanding of the right to health, not to reject the right to health. Nor do I believe the language of rights inapplicable to health. Rather, I agree with the ICESCR’s drafters that the right to health is an important right, but argue that it needs to be reconceived so as to place it on a par with, rather than above, other important rights. My goal is to motivate the need to redefine the requirements for health care.

I will raise four concerns about conceiving of the right to health as a right to maximum health:

1. It encroaches on resources that could be used to realize other rights, such as the rights to education and to housing, or to achieve discretionary goals;

2. It is unable to differentiate crucial health needs from peripheral claims;

3. It undermines national and subnational regulations on health care;

4. It rewards adversarial advocacy by physicians and lawyers on behalf of particular individuals at the expense of population health.

I’ll start with the first concern.

II. MAXIMIZATION

1. CROWDS OUT OTHER SOCIAL AND ECONOMIC RIGHTS

The right to health is the only right the ICESCR defines as a right to the highest attainable—maximum—standard. The rights to food and shelter are rights to adequate food and shelter, not to the maximum. The right to work is the right to “just and favourable conditions of work” which ensure workers a “decent living,” not to maximally remunerative or pleasant work. This difference between the right to health and other rights potentially produces a situation in which the right to maximum health engulfs all resources not explicitly reserved for other ends.