Healthism

HEALTH-STATUS DISCRIMINATION AND THE LAW

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What Is Healthism?

1.1. INTRODUCTION

The American Health Care Act of 2017 will

> allow insurance companies to require people who have higher health care costs to contribute more to the insurance pool. That helps offset all these costs, thereby reducing the cost to those people who lead good lives, they're healthy, they've done the things to keep their bodies healthy. And right now, those are the people – who've done things the right way – that are seeing their costs skyrocketing.
>
> U.S. House of Representatives, Mo Brooks (Republican – Alabama), May 4, 2017

People who "lead good lives" and "who've done things the right way" deserve to pay less for health care. But people who lead "bad lives" and have done things the "wrong way" deserve to pay more. That attitude is the essence of healthism: permitting – and even *encouraging* – discriminatory treatment based on an individual's health status.

Health status, like many prohibited bases for discrimination, often is not the result of good or bad living, or of doing things the right or wrong way. Even conduct that appears voluntary at first blush, in fact, may be the product of myriad interconnected factors. This book comprehensively examines the pervasiveness of health-status discrimination in law and society and urges that, at least in some instances, such discrimination should not be tolerated.

US law recognizes a number of "protected categories," or bases on which individuals may not be treated unfavorably. Current federal law prohibits discrimination (to varying degrees, and in varying contexts) based on race, color, national origin, sexual orientation, sex/gender, pregnancy, disability,

genetic information, religion, military service, immigration status, and age.[1] Conspicuously absent from this list of protected statuses, though, is health. Should the law allow unhealthy individuals to be treated less favorably than healthy ones? Or should we recognize a new category of impermissible discrimination?

This book is about discrimination on the basis of health status, or, as we will call it, "healthism." Political scientists in prior work have used the term *healthism* to refer to the government's establishment of coercive health norms.[2] Under that view, human activities are categorized as healthy or unhealthy, with preference given to the former. Healthy is moral and patriotic, while unhealthy is immoral and polluted. We do not adopt that meaning of the word healthism but instead repurpose it to refer to health-status discrimination by government and private actors. It is a discriminatory "ism" akin to racism, sexism, ageism, and ableism.[3] Distinct from those other protected categories, however, health status does not presently garner independent legal protection.

Once attuned to the concept of healthism, it is easy to spot examples. Employers, insurers, health-care providers, retailers, manufacturers, airlines,

[1] The US Constitution prohibits discrimination on the basis of race, national origin, religion and – to a somewhat lesser degree – gender, illegitimacy, and, perhaps now, sexual orientation. The Equal Protection clause of the US Constitution states that no state shall "deny to any person within its jurisdiction the equal protection of the laws." US Constitution amend. 14, § 1. Courts have interpreted this provision with varying levels of scrutiny depending on the impacted group. *See* 3 Treatise on Const. L. § 18.3(a). While discrimination on the basis of sexual orientation is not officially deemed a suspect class, US Supreme Court jurisprudence may open the door to heightened scrutiny of possible cases of such discrimination. *See* Mark P. Strasser, *Obergefell's Legacy*, 24 *Duke J. Gender L. & Pol'y* 61, 88 (2016). ("Perhaps in light of *Romer*, *Lawrence*, *Windsor* and *Obergefell*, the Court will soon announce that orientation is suspect or quasi-suspect.") The First Amendment outlaws religious discrimination by forbidding any law "respecting an establishment of religion, or prohibiting the free exercise thereof." US Const. amend. 1. By statute, Congress has limited certain private actors from discriminating also on the basis of disability, pregnancy, genetic information, immigration status, or military affiliation. *See* Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (codified at 42 U.S.C. § 2000e-(k)) (1976 & Supp. II 1978); Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified as amended at 42 U.S.C. §§ 12101–213 (2013)); Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (codified as amended in scattered sections of 26, 29, and 42 U.S.C.); Immigration and Nationality Act § 247B, 8 U.S.C § 1324b (1996); Uniformed Services Employment and Reemployment Rights Act of 1994, 38 U.S.C. §§ 4301–35 (2012).

[2] Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 *Univ. Ill. L. Rev.* 1159, 1171 (2012). ("The traditional concept of healthism involves the government's promotion of coercive health norms, and its attempts to impose lifestyle choices deemed 'healthy' on its citizens.")

[3] Jessica L. Roberts and Elizabeth Weeks Leonard, *What Is (And Isn't) Healthism*, 50 *Ga. L. Rev.* 833, 838 (2016); *see also* Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 *Iowa L. Rev.* 571, 592 (2014).

regulators, and public officials increasingly probe our personal lives and data sources for information that they deem relevant to their operations and interests. Health information is of particular and increasing interest. Both private and public actors make decisions about which opportunities to offer – or to deny – to groups or individuals based on their perceived health, or otherwise disadvantage subject people labeled as unhealthy.

Consider one university's plan to require all freshmen to wear Fitbits to track their steps, heart rates, and fitness activities.[4] The data are then sent directly to a central computer at the university, accessible by administrators and faculty. Oral Roberts University hails the program as a success and notes that seventy employers have followed suit.[5] Similarly, retailers and employers may be able to learn about a woman's pregnancy, or even her plans to become pregnant, based on her buying patterns or changes in pharmaceutical purchases.[6] Those examples involve use of otherwise private health information to invite a host of potentially discriminatory policies. Other examples reveal outright bias against individuals based on health status. During the 2016 presidential campaign, now President Donald J. Trump commented pejoratively on private individuals' disabilities and physical appearances.[7] Physicians decline to treat high-need patients. Employers adopt policies against hiring individuals who engage in health-risky behaviors, such as tobacco use. Reproductive biologists specifically select against certain chromosomal traits or abnormalities.

Although health-status discrimination is not yet formally recognized, allegations of healthism have generated their fair amount of litigation against a variety of different kinds of defendants, including employers, health-care providers, and businesses. Consider six-year-old Mackenzie Gonzalez, who was

[4] Jessica Chasmar, *Oklahoma University Requires Freshmen to Wear Fitbit, Track 10K Steps per Day*, *The Washington Times* (Jan. 11, 2016), www.washingtontimes.com/news/2016/jan/11/oklahoma-university-requires-freshmen-to-wear-fitb/; Elizabeth Chuck, *Oral Roberts University to Track Students' Fitness Through Fitbits*, *NBC News: College Game Plan* (Feb. 3, 2016), www.nbcnews.com/feature/college-game-plan/oral-roberts-university-track-students-fitness-through-fitbits-n507661.

[5] Bill Sherman, *Fitbit Fitness Monitoring Program a Hit at ORU*, *Tulsa World* (Mar. 20, 2017), available at www.tulsaworld.com/homepagelatest/fitbit-fitness-monitoring-program-a-hit-at-oru/article_eae41a5e-830a-5270-98de-c1aa62aac28d.html.

[6] Kashmir Hill, *How Target Figured Out a Teen Girl Was Pregnant before Her Father Did*, *Forbes: Tech* (Feb. 16, 2012), www.forbes.com/sites/kashmirhill/2012/02/16/how-target-figured-out-a-teen-girl-was-pregnant-before-her-father-did/#2026394766668.

[7] Jenna Johnson, *Trump Attacks Former Miss Universe Who "Gained a Massive Amount of Weight" and Had "Attitude,"* *The Washington Post: Post Politics* (Sept. 27, 2016), www.washingtonpost.com/news/post-politics/wp/2016/09/27/trump-attacks-former-miss-universe-who-gained-a-massive-amount-of-weight-and-had-attitude/?utm_term=.0701dec95454; www.nbcnews.com/politics/2016-election/trump-s-worst-offense-mocking-disabled-reporter-poll-finds-n627736.

diagnosed with cancer in December 2008.[8] At the time, her father, Yovany Gonzalez, worked for Wells Fargo in Palm Beach, Florida, as a mortgage consultant. Like many Americans with health insurance, Gonzalez held a policy through his employer. In August 2010, however, the bank fired Gonzalez, a mere three days before Mackenzie was scheduled to go into surgery. Along with his job, Gonzalez and his family also lost their health insurance, leaving them unable to afford the costly treatment. As a result, the hospital canceled the surgery. In March 2011, just seven months later, Mackenzie died. In August 2012, Gonzalez filed suit against his former employer, arguing that Wells Fargo terminated him because his daughter's health-care costs were too high.

In 1994, Sidney Abbott got a cavity. Like most people with cavities, she decided to go to the dentist. She chose Dr. Randon Bragdon. On her new patient intake form, Abbott indicated that she was HIV-positive, though asymptomatic. As a result, Dr. Bragdon refused to treat her in his office. Instead, he agreed to fill her cavity in the hospital, but Abbott would have to cover those additional expenses herself. She sued, alleging discrimination on the basis of her HIV status, and took her case all the way to the US Supreme Court.

Kenlee Tiggeman, who weighed about 300 pounds, was shocked when she tried to board her Southwest Airlines flight in 2011 and was told she needed to purchase a second ticket.[9] According to Tiggeman, Southwest employees humiliated her in front of other passengers by laughing at her and asking for proof of her weight. One gate agent apparently told Tiggeman that she was "too fat to fly." Tiggeman filed a lawsuit against the airline, which was eventually thrown out for procedural reasons.

You will learn more about these and many other stories as you read this book. Were the policies and decisions described fair or rational? Or were they unjust or intrusive? And what, if anything, should the law do to regulate these practices? These are the questions that judges, legislators, and policy-makers must ask themselves. Among developed countries, America spends inordinately on health care, yet our people suffer poorer health status comparatively.[10] The implications for health-status discrimination, thus, are widespread.

[8] Bonnie Kavoussi, *Yovany Gonzalez's Wells Fargo Lawsuit Alleges Bank Fired Him, Cut Dying Daughter's Health Insurance, Huffington Post* (Aug. 7, 2012), www.huffingtonpost.com/2012/08/07/wells-fargo-yovany-gonzalez_n_1751461.html; Christine Roberts, *Florida Man Says Wells Fargo Sacked Him Over Daughter's Cancer Treatment Cost, NY Daily News* (Aug. 12, 2012), www.nydailynews.com/news/national /florida-man-wells-fargo-sacked-daughter-cancer-treatment-costs-article-1.1134828.

[9] Associated Press, *Judge Rejects Woman's 'Too Fat to Fly' Lawsuit, Times-Picayune* (Nov. 1, 2012), www.nola.com/crime/index.ssf/2012/11/judge_rejects_womans_too_fat_t.html.

[10] David Squires and Chloe Anderson, *U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries* (The Commonwealth Fund, Oct. 2015), www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/oct/1819_squires_us_hlt_care_global_perspective_oecd_intl_brief_v3.pdf.

Our book catalogs the many ways that government and private entities differentiate on the basis of health status and the implications of those policies. It draws examples from a wide range of contexts, including the protections offered by civil rights and privacy laws; the Patient Protection and Affordable Care Act's rejection of health-status discrimination in private health insurance sales and pricing; and the potential for personal injury law to disfavor the unhealthy.

We recognize that the law can be a powerful tool to promote wellness and encourage healthy lifestyle choices. Yet classifying people based on their perceived health can also lead to stigma and compound other disadvantages. Accordingly, we argue that distinctions based on health are desirable in some contexts, but problematic in others. Viewing this issue through the lenses of social advocacy and health promotion, we conclude that sometimes the law should permit or even encourage health-based distinctions, and sometimes it should prohibit them as unlawful. We maintain that our approach more accurately – and more honestly – captures the wide range of concerns facing law and policy-makers.

This book provides a roadmap for navigating the treacherous terrain of health-status discrimination. Chapters 1 and 2 define key terms, explaining more precisely what we mean by the term healthism – answering initial objections to recognizing new prohibited bases for discrimination, and outlining a theoretical framework for approaching the problem – which recognizes that not all forms of differential treatment based on health status are necessarily healthist.

Chapters 3–5 provide real-world examples. We survey key categories of existing US laws that partially, but incompletely, address healthism, thus highlighting the need for a new conceptual framework. In particular, existing laws protecting privacy or prohibiting discrimination based on disability and genetic information fail to capture all instances of health-status discrimination that we would deem undesirable. Health insurance law, much of which is in flux under a new presidential administration, leaves gaping holes through which insurers may discriminate based on health status, as in the Mackenzie Gonzalez example above. Judge-made private law, namely torts and contract, contain ample opportunities for health-status discrimination.

Chapter 6 outlines a framework, containing a set of factors, for distinguishing between "good" (or health-promoting) distinctions and "bad" (or healthist) ones. Thus, the final chapter draws together a critical insight from Chapters 1 and 2

that not all instances of health-based differentiations are undesirable or normatively wrong and applies our framework to the various examples of health-status discrimination from Chapters 3 through 5. Indeed, one of the challenges of recognizing a new "ism" based on health is that treating individuals differently based on health is not necessarily harmful. In fact, in some cases, health-status discrimination may benefit the individual or society. Thus, we provide a blueprint for drawing those distinctions and navigating the divide.

Here, in Chapter 1, we begin with the concept of healthism. We contend that an entity discriminates on the basis of health status when it distinguishes – intentionally or unintentionally – based on health in such a way that produces a normative wrong. Drawing from antidiscrimination theory, we unpack essential elements of that definition, including "health," "health status," and "normative wrong." This clear definition of healthism allows us to distinguish between socially harmful and socially beneficial differentiations based on health status in later chapters.

1.2. HEALTHISM: THE CENTRAL CONCEPT

The fact that healthism has not already been the subject of widespread legal regulation begs the question: Why is it problematic? We propose that healthism matters for at least two main reasons. First, people perceive many healthist practices to be unfair. In other words, while much of healthism is legal, it still may raise important – and legitimate – moral concerns. Second, healthist practices threaten to exacerbate existing social inequalities, including health disparities.

People face real disadvantages based on their health-related attributes. Rates of weight discrimination – particularly among women – rival those of race discrimination and permeate all aspects of life, including education, health care, public life, and employment.[11] This negative differential treatment has financial as well as psychosocial implications, with weight discrimination linked to depression, anxiety, social rejection, suicide, avoiding medical treatment, and unhealthy behaviors.[12] Perhaps not surprisingly, this widespread discrimination likely stems from negative stereotypes that heavier individuals are lazy, stupid, undisciplined, sloppy, and at fault for their weight.[13] Yet despite these beliefs, the support for laws prohibiting weight discrimination has continued

[11] Jennifer L. Pomeranz and Rebecca M. Puhl, *New Developments in the Law for Obesity Discrimination Protection*, 21 *Obesity* 469, 469 (2013).

[12] Ibid.

[13] Rebecca M. Puhl, Young Suh, and Xun Li, *Legislating for Weight-based Equality: National Trends in Public Support for Laws to Prohibit Weight Discrimination*, *Internat'l J. Obesity* 1, 1 (2016).

to increase among liberals and conservatives alike. A 2016 survey found that 78 percent of respondents support laws forbidding weight discrimination in employment.[14]

In fact, eighty-eight percent of Americans believe that employers should not make hiring decisions based on whether an applicant smokes or is overweight.[15] Yet despite public opinion, a wide range of employers have adopted policies that ban hiring nicotine users. Not surprisingly, many viewed the policies as unfair. One public health professor called nicotine hiring bans "a form of employment discrimination," in part because they involve an employer "making a hiring decision based on a group someone belongs to, not his or her qualifications for the job."[16] And a state politician stated that "[e]ven if [the obesity ban] wasn't *illegal*, the policy was *discriminatory*."[17]

In addition to being discriminatory, critics also described the nicotine hiring ban as "an invasion of privacy and really overreaching"[18] and as "a step too far" that "extends far too deeply into the private lives of prospective workers."[19] Commentators feared that those policies were the tip of the iceberg and could lead to even more intrusive kinds of actions by employers. One editorial inquired: "If employers routinely reject people who engage in risky, but legal, behavior on their own time, what about such things as overeating or drinking too much alcohol?"[20]

Permitting healthism could eventually lead to restrictions on all kinds of private actions because so much of our conduct affects our health,[21] including

[14] Ibid.

[15] Rebecca Riffkin, *Hiring Discrimination for Smokers, Obese Rejected in U.S.*, *Gallup* (July 22, 2014), www.gallup.com/poll/174035/hiring-discrimination-smokers-obese-rejected.aspx.

[16] Roberts, note 3, at 571, 592 (quoting Renée C. Lee, *Hospitals Turn Away Applicants Who Smoke*, *Hous. Chron.* (Oct. 19, 2012) (quoting Michael Siegel), www.chron.com/news/houston-texas/houston/article/Hospitals-turn-away-applicants-who-smoke-3988931.php).

[17] Ibid. at 593 (quoting Erin Pradia, *Citizens Medical Center Reverses Ban on Hiring Obese People*, *Victoria Advoc.* (Apr. 12, 2012) (quoting Alex Hernandez), www.victoriaadvocate.com/news/2012/apr/11/ep_citizens_health_041212_173212).

[18] Ibid. at 592 (quoting Renée C. Lee, *Hospitals Turn Away Applicants Who Smoke*, *Hous. Chron.* (Oct. 19, 2012) (quoting Dotty Griffith), www.chron.com/news/houston-texas/houston/article/Hospitals-turn-away-applicants-who-smoke-3988931.php).

[19] Ibid. at 592 (quoting *Editorial: Not Hiring Smokers Crosses Privacy Line*, *USA Today* (Jan. 29, 2012), http://usatoday30.usatoday.com/news/opinion/editorials/story/2012-01-29/not-hiring-smokers-privacy/52874348/1).

[20] Ibid. at 593 (quoting *Editorial: Not Hiring Smokers Crosses Privacy Line*, *USA Today*, Jan. 29, 2012, http://usatoday30.usatoday.com/news/opinion/editorials/story/2012-01-29/not-hiring-smokers-privacy/52874348/1).

[21] Lewis Maltby, president of the National Workrights Institute, has observed: "The more we learn about the relationships between behavior and health, the more we realize that everything we do in our private lives affects our health. If employers are permitted to control private behavior when it is related to health, virtually every aspect of our private lives is subject to employer

our eating choices, sex lives, recreational conduct, and sleep patterns. Thus, in addition to fairness, opponents of healthism also raise related concerns about protecting privacy, respecting autonomy, and avoiding paternalism. Unchecked, healthism could threaten our ability to freely make decisions about our private lives.

Healthist practices also demand legal attention because they disproportionately impact certain historically disadvantaged populations.[22] Health disparities research from 2016 found that non-white and low-income populations have reduced health-care access, are less likely to have health insurance, and are more likely to encounter barriers when seeking health care.[23] Likewise, people with disabilities are less likely to receive preventative care, and are more likely to have poor health outcomes and to engage in unhealthy behaviors.[24] Because members of those groups are in poorer relative health, policies that discriminate based on health status will inevitably have a greater impact on them. Thus, in addition to the challenges that they already face, these populations have the added disadvantage of discriminatory treatment on the basis of health, whether it is in the context of health insurance, employment, health-care access, public health, government programs, or commerce. Accordingly, facially neutral policies, such as taxes on tobacco products or sugary soft drinks, may disparately impact certain already-disadvantaged groups.

Further complicating matters is the reality that disadvantaged populations encounter greater structural barriers to adopting health-promoting behaviors.[25] People need resources to purchase healthy food, find opportunities to exercise, quit smoking, and even get enough sleep. Existing literature on social determinants of health reveals that certain populations encounter roadblocks on their paths toward healthy living.[26] Common structural barriers include

control." Lewis Maltby, *Whose Life Is It Anyway?: Employer Control of Off-Duty Smoking and Individual Autonomy*, 34 *Wm. Mitchell L. Rev.* 1639, 1641 (2008).

[22] Roberts, note 3, at 616–18.

[23] Agency for Healthcare Research and Quality, National Healthcare Quality and Disparities Report: Chartbook on Access to Healthcare (2016).

[24] Disability and Health, Healthy People 2020, www.healthypeople.gov/2020/topics-objectives/topic/disability-and-health.

[25] Roberts, note 3, at 616–18; Jessica L. Roberts and Leah Fowler, *How Assuming Autonomy Undermines Wellness Programs*, 27 *Health Matrix* 101 (2017).

[26] For example, medical ethicist Harald Schmidt explains: "A law school graduate from a wealthy family who has a gym on the top floor of his condominium block is more likely to succeed in losing weight if he tries than is a teenage mother who grew up and continues to live and work odd jobs in a poor neighborhood with limited access to healthy food and exercise opportunities. And he is more likely to try." Harald Schmidt, Kristin Voigt, and Daniel Wikler, *Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives*, 362 *New Engl. J. Med.* e3(1) (2010).

living in a food desert (or a fast food swamp); lacking access to safe, affordable opportunities to exercise like parks or public pools; and not being able to pay for the child care necessary to make time to exercise or sleep. Rationalizing healthism as a means to encourage people to be healthy assumes that they are in poor health for reasons within their control. We explore the limits of personal autonomy to achieve optimal health status throughout this book.

Thus far we have established that healthism is not only potentially stigmatizing, unfair, and intrusive but also may perpetuate – or even fortify – existing social disparities, creating further impediments for already-disadvantaged populations. If we wish to regulate healthism, however, we will first need a clear definition of precisely which kinds of distinctions based on health status may constitute discrimination. Explanations of key components of our definition – including discrimination, healthy, health status, and normative wrong – follow.

1.2.1. *Discrimination*

The first step to a working definition of healthism is to spell out precisely what we mean by "discrimination." In the simple, dictionary sense, to discriminate simply means to differentiate.[27] People then discriminate on a daily basis. Insurers discriminate based on risk, lenders discriminate based on financial history, and employers discriminate based on education and experience. We even discriminate when we choose friends and romantic partners. This definition of discriminate is what forms the root of adjective *indiscriminate*, meaning not selective.[28]

In that sense, prohibiting people from discriminating, or differentiating, altogether would be not only undesirable but also nearly impossible. Consequently, when we talk about antidiscrimination law, we are inevitably talking about a particular subset of discriminatory actions. Yet which ones? The answer is the types of differentiation that violate certain important social norms, typically, fairness and equality. While discrimination has a value-neutral meaning, frequently when people say an action is "discriminatory"

[27] *See The Oxford English Dictionary* 757–8 (Oxford University Press, 2nd edn., 1989) (defining "to discriminate" as "to divide, separate, distinguish"); *see also* Robert K. Fullinwider, *The Reverse Discrimination Controversy: A Moral and Legal Analysis* 10–11 (Roman & Littlefield Publishers, 1980) (explaining that the term "discrimination" is "morally neutral"); *see also* Roberts, note 2, at 1163; Roberts, note 3, at 591; Jessica L. Roberts, *Protecting Privacy to Prevent Discrimination*, 56 *Wm. and Mary L. Rev.* 2097, 2109 (2015); Roberts and Leonard, note 3, at 838–9.

[28] "Indiscriminate," *The Oxford English Dictionary* (3rd edn., 2010) (defining an indiscriminate person as "not using or exercising discrimination").

they mean that the differentiation is somehow wrong or unfair.[29] In other words, there is an inherent value judgment. In fact, the legal and political meaning of discrimination is so widely accepted as pejorative that merely *calling* something discriminatory may be enough for some people to consider it problematic. Discrimination is the kind of distinction that goes against the way at least some people think the world *should* be. We refer to these violations of social mores as "normative wrongs." Thus, for differentiation to be "discrimination" it must result in a normative wrong. We further consider the meaning of normative wrong below and in Chapter 2.

Importantly, discrimination is not limited to differentiations that *intentionally* produce disadvantage. Discrimination can also encompass disadvantage that is unconscious or otherwise unintentional. Antidiscrimination law sometimes allows people to sue for "disparate impact," when an action or policy disproportionately harms a particular group, regardless of intent.[30] Disparate impact signifies discrimination by result, not by design.[31] Height requirements provide a prototypical example. While an employer that requires its employees to be 5′77″ so that they can properly operate equipment does not intend to exclude women, more men than woman will be eligible for the position simply because men tend to be taller.[32] With respect to healthism, weight requirements disparately impact overweight people, and occupational standards may screen out people who have health conditions like hepatitis that make them more vulnerable to toxicity. We explore how these kinds of cases have played out in the courts in Chapter 3.

Next, consider how socially undesirable differentiation operates. One popular set of frameworks for understanding discrimination is anticlassification versus antisubordination.[33] On one hand, discrimination can mean merely *classifying* people based on a particular protected status – for instance, race, sex/gender, or disability. On the other hand, discrimination can also signify *subordinating*

[29] Roberts, note 2, at 1172–4; Roberts, note 3, at 591; Roberts, note 27, at 2109–12; Roberts and Leonard, note 3, at 839.

[30] *See* Lex K. Larson, *Employment Discrimination*, ch. 20: The Basics of Disparate Impact Theory 2–20 (Matthew Bender, 2nd edn., 2016); *see also* Roberts, note 2, at 1172–3; Roberts, note 27, at 2120–1; Roberts, note 3, at 617; Roberts and Leonard, note 3, at 840.

[31] *Alexander* v. *Choate*, 469 U.S. 287, 292 (1985).

[32] *See e.g.*, *Boyd* v. *Ozark Air Lines*, 568 F.2d. 50, 53 (8th Cir. 1977) (holding that a height requirement of 5'7" has a disparate impact on women and instituting a 5'55" requirement as a less discriminatory alternative).

[33] Jack M. Balkin and Reva B. Siegel, *The American Civil Rights Tradition: Anticlassification or Antisubordination?*, 58 *U. Miami L. Rev.* 9, 9–10 (2003); *see also* Roberts, note 27, at 2123–5; Roberts and Leonard, note 3, at 839–40. There are of course other antidiscrimination paradigms. *See* Jessica A. Clarke, *Protected Class Gatekeeping*, 92 *N.Y.U. L. Rev.* 101, 145–55 (2017) (discussing the antiessentialism and anti-balkanization theories of antidiscrimination).

one particular group or groups – for instance, people of color, women, or people with disabilities – regardless of intent. Under either approach, healthism produces disadvantage related to a person's health status. As we will explain, our healthism rubric fits most comfortably under the antisubordination view.

Antisubordination focuses on group harm, seeking to raise the social status of historically subjugated populations. Antisubordination embraces both the disparate impact actions described above and positive differential treatment like affirmative action or accommodations for people with disabilities. By contrast, anticlassification centers on protected classes, prohibiting any intentional differentiation – good or bad – but not intervening in cases of inadvertent discrimination. Anticlassification does not, then, support claims for disparate impact or positive differential treatment.

In the case of healthism, we can either describe the socially undesirable differentiation as classifying on the basis of health status or as subordinating people deemed unhealthy.[34] Antisubordination would seek to combat the social subjugation of people labeled as unhealthy, allowing claims for disparate impact and supporting positive differential treatment. Anticlassification would simply outlaw all intentional health-based distinctions, taking a "health-blind" position.

Both paradigms have their challenges. With respect to antisubordination, people with disabilities, overweight people, smokers, people with elevated levels of genetic risk, and individuals who are HIV-positive have surely faced discrimination in one form or another. It is unclear, however, whether people perceived to be unhealthy, as a collective group, have been the victims of widespread social subjugation. Thus, simply making "unhealthy" a prohibited basis for discrimination may not be workable or desirable. By way of comparison, however, "disability," which is a legally protected category, is a similarly broad umbrella that encompasses people with a wide range of impairments. Therefore, the heterogeneity of the proposed protected status does not in and of itself rule out possible antidiscrimination protection.

Anticlassification raises its own issues. First, as we explain in Chapter 2, not all intentional health-status differentiations are discriminatory. Universally prohibiting public and private institutions from considering health could undermine efforts to promote and improve health and other social goods. Moreover, anticlassification's exclusion of unintentional discrimination and aversion to positive differential treatment are also not well-tailored for healthism. As we

[34] *See* Roberts, note 2, at 1174 (explaining that "health-status discrimination can be thought of in two ways: discrimination on the basis of a protected trait [health status], or alternatively as discrimination against a particular disadvantaged group [the sick]"); Roberts and Leonard, note 3, at 841.

will explain, a number of policies could have a harmful disparate impact. Moreover, certain kinds of positive differential treatment related to health status may be socially desirable. For example, it may be good policy to facilitate smokers' access to resources to quit smoking, to provide Medicaid benefits to pregnant women, and to prioritize sicker patients over healthy ones in donor organ–allocation decisions. By the same token, insurance coverage policies covering longer post-partum hospital stays following a caesarean, as opposed to vaginal delivery, could be said to be healthist despite good, rational, medically appropriate reasons for the differentiation.

Between the two views of discrimination, our definition of healthism most clearly tracks antisubordination, but neither is a perfect fit.[35] While antisubordination and anticlassification are foundational ways of understanding discrimination, other theories have also been influential. For example, antiessentialism rejects the notion that there are essential attributes to any particular identity category, like race or sex.[36] For example, someone who essentializes sex would assume that all women's experiences of raising children are largely the same. In reality, however, all of our social statuses – race, sex/gender, education, class, religion, and so on – shape our lives in interrelated and overlapping ways. Consequently, there is no "woman's experience" or "black person's" experience that can be separated from a person's other identities. To reduce a person to a single aspect of her identity engages in essentialism. Antiessentialism, then, seeks to dismantle essentialism and to treat individuals as whole, multifaceted persons.

Essentialism can also occur regarding health. For example, a person with schizophrenia becomes "a schizophrenic." Illness involves its own culture and social meaning. Medical sociologists have long identified the concept of the "sick role," which carries with it customary rights and obligations.[37] Adopting the sick role exempts a person from normal social roles and absolves her of personal responsibility for her condition, while obligating her to try to get well and to seek treatment. If people are blamed for their ill health, however, they may not be accorded special solicitude or relief when ill. Also, people may reject the sick role by not wanting to be dependent or to become a "passive patient."

When we reduce a person to a single health-related attribute – weight, smoking, HIV, mental illness, or even cancer – we are engaging in health

[35] Roberts and Leonard, note 3, at 856–7.

[36] Trina Grillo, *Anti-Essentialism and Intersectionality: Tools to Dismantle the Master's House*, 10 *Berkeley Women's L.J.* 16, 17 (1995).

[37] *See* Talcott Parsons, *The Social System* (2nd edn., 1991) (first published 1951) (introducing the concept of the sick role).

essentialism. Hence, our theory of healthism is committed to ensuring that we treat people as full human beings, not simply as their health status.

1.2.2. *Health*

In considering whether to prohibit health-status discrimination, we must have a good sense of what health means in the first place. The World Health Organization (WHO) defines health as "[a] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[38] The WHO definition is a broad, aspirational standard, which we do not find workable on a practical level. If we base our definition of health on WHO's idea of health, then many of us have never been healthy a day in our lives!

Health has both descriptive and normative elements.[39] On the descriptive level, definitions of health frequently refer to how well a body functions. Under this definition, disease or ill health is a functional limitation. For example, someone with diabetes is ill because her body does not efficiently break down sugar. A person with cancer is ill because her body produces too many malignant cells. However, thinking of health in those terms requires agreeing on a baseline level of functioning. That is, it requires a concept of normalcy.[40] If I tell you that your blood pressure is 129/82, you have no way of knowing whether that number is "high" without the added information that "normal" blood pressure is under 120/80. However, what is normal inevitably shifts. Humans tend to live longer and to be taller and stronger than we were a century ago. Thus, the center of the bell curve always moves, making functionalism as a means of defining health less stable than it might initially appear.

Additionally, functional limitation alone may not always result in a person being labeled "unhealthy." Para-athletes experience functional limitations related to their disabilities, but because they are world-class athletes one would be hard-pressed to call them unhealthy. Likewise, a relatively minor functional problem, like a blister or a cavity, is not typically considered a sign of ill health.[41] Definitions of health, therefore, have normative elements. As a result, whether a particular condition or state is labeled unhealthy will depend, at least in

[38] Constitution of the World Health Organization (New York, July 22, 1946), 14 U.N.T.S. 185, entered into force Apr. 7, 1948 www.who.int/governance/eb/who_constitution_en.pdf; *see also* Roberts and Leonard, note 3, at 853.

[39] *See* Christopher Boorse, *On the Distinction between Disease and Illness*, 5 *Phil. & Pub. Aff.* 49, 52–3 (1975); *see also* Roberts and Leonard, note 3, at 853–5.

[40] Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 *Minn. L. Rev.* 1963, 1978 (2013).

[41] *See* Roberts and Leonard, note 3, at 855.

part, on the perceived desirability of that status.[42] Consider an overweight person with no accompanying health issues. She may be considered "unhealthy" based on her weight even without any functional limitations, simply because society deems being overweight undesirable. The "Health at Every Size" movement is a reaction to the common conception that being overweight in and of itself constitutes poor health. Health is, at least to some extent, in the eye of the beholder. It bears emphasis that all definitions of health (including functionalist ones that require setting a norm) are socially constructed.

But the fluidity of what constitutes health aside, our project requires us to have a workable definition. Because we all experience unwanted bodily malfunctions – such as acne, headaches, occasional insomnia, or situational anxiety – we also include an element of *severity* to provide clearer boundaries for the degree of poor health that may be the basis for antidiscrimination claims. Combining both descriptive and normative elements, we define "unhealthy" to mean having a condition – typically related to a functional limitation of a certain degree of severity – that the individual or society regards as undesirable.[43] For example, suppose a person is infertile, meaning that person's reproductive system is not functioning properly; however, we would not consider her unhealthy unless she desires to bear children, or society deems it undesirable to be infertile. The social undesirability of certain conditions may vary by culture, geography, or point in time.

1.2.3. *Health Status*

Healthism includes discrimination against people labeled as unhealthy, under the definition above. A more radical feature of our healthism project is extending our definition to include discrimination on the basis of "health status," including not only individuals suffering from recognized, "static" health conditions but also individuals who engage in *behaviors* associated with poor health. Expanding the scope of our project in this way presents challenges because any number of behaviors, habits, conditions, opportunities, experiences, and exposures may bear on our health. Thus, to say that a particular entity adopts a policy that discriminates based on "health status" in this more inclusive sense, we must clearly define that term and its boundaries.

As noted, our definition of health status includes both health-related traits and health-related conduct.[44] Health-related traits, as we use the term here,

[42] Christopher Boorse, *On the Distinction between Disease and Illness*, 5 *Phil. and Pub. Aff.* 49, 50–7 (1975); *see also* Roberts and Leonard, note 3, at 853–6.
[43] Roberts and Leonard, note 3, at 855.
[44] Roberts, note 3, at 604–7; Roberts and Leonard, note 3, at 858–61.

mean static conditions. Diagnosed conditions, medical records, and genetic test results are all traits. Nicotine use – particularly smoking, which has been linked to so many potential health problems – is the paradigmatic health-related conduct. By the same token, drinking alcohol, not wearing a seatbelt, skiing, mountain climbing, tanning, and having stressful jobs or relationships may also expose individuals to greater health risks. Accordingly, all these habits, behaviors, and activities may be considered "health statuses" for purposes of our definition.

Indeed, the modern understanding of health recognizes that virtually everything we do impacts our health. If nutritionists and physicians recommend drinking eight glasses of water a day, but I do not follow this advice, should I be considered "unhealthy"? If I could prove that I was discriminated against based on my low water consumption, would I have a case for healthism? We think not. Just as we qualify our definition of "unhealthy" based on severity (thereby generally excluding conditions such as cavities and acne), we also limit the category of health-related conduct to activities tending to correlate with serious health conditions deemed undesirable by the individual or society. Accordingly, working in stressful or high-risk workplaces could be considered health-related conduct for purposes of our definition. Stress can lead to debilitating anxiety, heart disease, and general reduction in immune system functioning – conditions that most people consider undesirable. A more dramatic example is a victim of an abusive relationship, the stress of which can lead to a range of physical and psychological health conditions.

Including health-related conduct is consistent with modern antidiscrimination theory. Historically, antidiscrimination law has been largely trait-centric, focusing protecting characteristics deemed "immutable." The rationale is that it is unfair to disadvantage someone for something outside of her control.[45] If a person chooses, causes, or could change the attribute, however, that trait would not warrant antidiscrimination protection. Whether intentional or not, focusing on immutability encourages people to alter their behavior or to assimilate to avoid facing disadvantage. We join leading scholars in rejecting immutability as a justification for antidiscrimination law.[46]

Immutability does not lend itself to healthism because so much health status relates to conduct and, therefore, is potentially mutable. Despite the challenges that our expanded definition presents, including conduct is essential to our project. Drawing a line between traits and conduct would be difficult and artificial. Health-related traits and health-related behavior necessarily overlap; many of our traits are the results of our conduct. Smoking may lead to lung

[45] Jessica A. Clarke, *Against Immutability*, 125 *Yale L.J.* 2, 4 (2015).
[46] Ibid.

cancer. Eating sugary foods may lead to diabetes. Drinking alcohol may lead to liver disease. The connection between traits and conduct could even extend to the cellular level. We all acquire our DNA by chance from our parents. This genetic information is then a static trait. But it is not that simple. Although much of our genetic information is fixed at birth, our conduct can also affect our DNA. It can impact both our gene structure through epigenetic changes and mutations and how our genes function (or malfunction).[47] Differentiating the trait from the underlying conduct can present a serious challenge.

We also reject perceived voluntariness as a touchstone for protected status. While holding people accountable for their health-related conduct resonates with the American ideal of personal responsibility,[48] the social determinants of health and the limits of autonomy demonstrate that not all actions are truly voluntary.[49] Returning to the domestic violence victim: If she stays in the abusive relationship, is that voluntary? Should she be denied any protection from discrimination for the resulting health conditions? If someone remains in a high-stress job due to financial and job-market constraints, is that voluntary? If a person cannot lose weight because she cannot afford healthy food and lacks time and access to safe exercise options, is she overweight by choice? Additionally, even voluntary conduct might warrant protection if it is private, legal, and does not affect others.

1.2.4. *Normative Wrong*

We have now almost arrived at a workable definition of healthism. Healthism, as we define it, means both intentional and unintentional differentiations that disadvantage people based on either their health status or their perceived unhealthiness. We focus on a broad range of disadvantaging treatment, including policies, practices, or patterns of behavior that are part of an organization's structure, such as an employer's general refusal to hire elderly or overweight workers. But even these limitations are not enough. People who have not graduated from college face clear disadvantages in employment, but few would call that discrimination. And it is not about being rational either. An employer who refuses to hire graduates of the University of California–Los Angeles because the company's president went to the University of Southern California would be discriminating arbitrarily, yet the policy would violate no

[47] *See* Mark Rothstein, Yu Cai, and Gary E. Marchant, *The Ghost in Our Genes: Legal and Ethical Implications of Epigenetics*, 19 *Health Matrix* 1 (2009).

[48] Roberts and Fowler, note 25.

[49] Ibid.; Roberts and Leonard, note 3, at 893–4.

law.[50] Here we return to the meaning of discrimination, focusing now on its normative implications. We ask, what makes disadvantaging people based on health status wrong?

Often the distinguishing factor between wrongful discrimination and socially acceptable differentiation is the basis of the discrimination itself. Whether a status warrants antidiscrimination protection is highly contextual, and dependent on culture and history.[51] Prohibited bases for discrimination usually have personal or social significance or have been the foundation of past subordination.[52] Race and ethnicity, sex/gender, religion, age, and disability are well-accepted antidiscrimination categories.[53] The question then remains, should the law prohibit discrimination based on health status?

It would be easy to fall back on the disparate impact that healthism has on other protected bases like race or disability to justify antidiscrimination protection. That approach, however, does not require looking to health status as an independent basis. In other words, the fact that certain groups are disparately impacted because of their health status does not answer the question whether healthism constitutes its own independent form of discrimination.[54] Importantly, health-status discrimination does not always overlap with already-recognized forms of discrimination.

As explained earlier in this chapter, existing antidiscrimination theories do not neatly apply to healthism. Healthism is not categorically undesirable in the same way racism is. Moreover, health status encompasses not only groups and traits – the familiar territory of antidiscrimination laws – but also conduct. Yet just because healthism does not fit squarely into an existing antidiscrimination paradigm does not mean that it fails to generate a normative wrong. In fact, as we discuss at length in Chapter 2, healthism can violate important values

[50] This example originally appeared in Roberts, note 27, at 2110.

[51] Larry Alexander, *What Makes Wrongful Discrimination Wrong?: Biases, Preferences, Stereotypes, and Proxies*, 141 *U. Pa. L. Rev.* 149, 153 (1992) ("[T]he line between wrongful and acceptable discrimination is, in most cases, difficult to locate with precision because it is historically and culturally variable."); *see also* Roberts, note 2, at 1172–3 (providing various illustrations of how the distinctions among discrimination rely on culture and history); Roberts, note 27, at 2110 ("Often the determination of whether a practice is discriminatory in the pejorative sense turns on whether the conduct in question leads to disadvantage on the basis of a characteristic that either has personal or social relevance, or has been the basis for systematic social subjugation in the past."); Roberts and Leonard, note 3, at 854.

[52] Roberts, note 27, at 2110–12; Roberts and Leonard, note 3, at 839.

[53] Roberts, note 27, at 2110 (citing Civil Rights Act of 1964 § 703(a), 42 U.S.C. § 2000e-2(a) (2006); Americans with Disabilities Act of 1990 § 102(a), 42 U.S.C. § 12112(a) (2006); Age Discrimination in Employment Act of 1967 § 4(a), 29 U.S.C. 623(a) (2006)).

[54] Roberts and Leonard, note 3, at 856.

related to welfare, equality, liberty, and justice. Running afoul of these values is precisely what makes a health-based differentiation "wrong."

1.3. ANTICIPATED OBJECTIONS TO HEALTHISM

We recognize several important challenges for a theory of healthism, including some issues that we have already flagged: the heterogeneity of "health status" or the "unhealthy"; the inclusion of arguably voluntary behaviors bearing on health and the associated difficulty of determining what conduct is truly voluntary; the intersectional nature of health and health-status discrimination with other traits and bases for discriminatory treatment; and the existence of established legal protections for overlapping conditions, including – but not limited to – disability, pregnancy, genetic information, and age. Perhaps the biggest challenge to our project, however, is the fact that differential treatment based on health-status, in more than a few cases, will not be deemed normatively wrong.

Consider an employer's policy to refuse to hire tobacco users or obese workers. The employer undoubtedly singles out groups of potential workers, based on their health status, for less favorable treatment – namely, refusal to hire. Thus, there is (1) differentiation (2) based on health status. The harder question is whether there is a normative wrong. The employer may argue that its hiring policy is utterly rational because it could readily anticipate that workers with those particular health statuses will be more expensive to insure; more likely to become ill and miss work; and less productive due to slower mobility, physical discomfort, and the need for smoke (or other) breaks. Because there are good reasons for the discriminatory treatment, the employer might assert that the policy should not be deemed healthist. As we discuss in Chapters 3 and 6, under our four guiding principles of health welfare, health liberty, health equality, and health justice, we reach a different conclusion for this example.

By the same token, the long-standing practice of health insurers before the Patient Protection and Affordable Care Act of 2010[55] (ACA) – the signature congressional health reform law enacted under President Barack Obama, discussed in depth in Chapters 3 and 4 – was to make decisions about which individuals to cover and how much to charge in premiums, based on individual risk profiles. Risk profiles include detailed personal information about existing health conditions, genetic predispositions, age, sex/gender, geography, weight,

[55] Patient Protection & Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2010), available at www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

employment, education, and other demographics – essentially, any data that would help an insurer predict an applicant's likelihood of using covered medical care. This practice of "experience rating" is commonplace in insurance. To issue a life insurance policy, for example, insurers typically require a physical exam. The insurer bases its decision of whether the person is an insurable risk and how much to charge in premiums on its estimate of life expectancy relative to the term of coverage. Likewise, automobile insurance policy premiums are lower for individuals with safe driving records, and auto insurers use statistical predictions based on age, sex/gender, and other demographics. Flood insurance may be unavailable or very expensive for a homeowner living in a flood plain (absent federal subsidies[56]).

Experience rating seems eminently rational. To be sure, health insurers would prefer not to insure individuals who are already ill or who are very likely to become ill. Viewing insurance as financial protection against unexpected risk, such an individual would hardly be considered insurable. There is no longer an unexpected risk but, rather, a known need for medical treatment. Even if an insurer were to issue a policy to someone with a known health condition, the insurer would rationally prefer to charge higher premiums to cover the greater risk – or, in the case of someone who is already sick, the certainty – of using medical care. By contrast, health insurers would prefer to insure individuals with little risk of needing health care and could offer them policies that cost less because the predicted exposure is much lower.

For an insurance risk pool to function properly, insurance companies require a mix of "good" (or low) and "bad" (or high) risk individuals. The low-risk individuals pay premiums in an amount that may well exceed the cost of medical care that they end up using. But if they are risk-averse, they may prefer paying an amount certain on a monthly basis rather than facing the uncertainty of unexpected catastrophic costs. The high-risk individuals may well use more medical care than they have paid in premiums, but the surplus premiums from the low-risk individuals end up covering those costs, as well as the insurers' overhead and profit. Depending on the composition of the risk pool, the insurer may have to increase premium rates across the board to generate adequate reserves to cover the costs of medical care utilized by the insured individuals. Even with decently accurate risk predictions and corresponding premium rates, and a balance of good and bad risks, insurers

[56] *See, e.g.*, National Flood Insurance Program, 42 U.S.C. § 4011 (2012); The National Flood Insurance Program, FEMA, www.fema.gov/national-flood-insurance-program (last accessed June 28, 2017).

themselves may be concerned about unexpectedly high claims from the individuals whom they insure. Accordingly, they may purchase reinsurance or "stop-loss" coverage – essentially, "insurance for insurers" – to reduce their own financial uncertainty.

Another element of insurable risk is that the loss is outside the insured's control. For that reason, life insurance policies typically exclude coverage for suicide, and liability insurance policies typically exclude coverage for intentional harms. Insuring such actions may lead to "moral hazard," meaning the increased tendency of individuals to engage in certain activities if they know that they are insured. In health insurance, moral hazard may manifest as individuals seeking more medical care than they would if they were uninsured. That tendency may be desirable, as in the case of preventive or diagnostic treatment, or undesirable in the case of emergency room care for nonemergency conditions. Health insurers "check" moral hazard by requiring copayments from the insured at the time of service, or applying deductibles, which require the insured to cover a certain amount of cost before the policy coverage kicks in.

The point of this discussion is that there are ample rational reasons for health insurance companies to discriminate based on the health status of individuals whom they choose to insure. The prevailing model of insurance – described in more detail in Chapter 4 – has long allowed experience rating in health insurance, as in other insurance contexts. The common law of private contracts – discussed at greater length in Chapter 5 – also largely privileges such practices, allowing private individuals to choose with whom they do business. But an insurer's refusal to sell a policy to someone who is ill operates, quite explicitly, as (1) differentiation (2) based on health status. On the question of normative wrong, insurers and free-market libertarians would argue that there is none. First, a health insurer should not be expected to insure against known health conditions. Moreover, low-risk individuals should not be expected to subsidize medical care provided to high-risk individuals. Finally, charging the same premiums regardless of how much medical care an individual uses only exacerbates moral hazard. What incentive – aside from safety and some sense of moral or legal duty – do I have to avoid traffic law violations if my auto insurance rates will not rise as a result?

To argue that experience rating in health insurance is normatively wrong and, therefore, healthist, we must espouse a different view of health insurance, as the framers of the ACA did. Instead of health insurance being a way for individuals to protect themselves against unknown financial risks, health insurance instead is a way for society to provide access to essential medical care to a substantially larger portion of the population. By design, low-risk

individuals subsidize high-risk individuals. Thus, this account of health insurance seeks to improve the health of the community and views access to health care as more of an entitlement than a privilege. Again, under our guiding theoretical principles, on balance, we deem experience rating in health insurance healthist.

Another argument against recognizing healthism is that policies that appear discriminatory may actually be health-neutral. For example, a commercial airline's decision to charge obese passengers for two seats may not discriminate based on health-status but, rather, is a health-neutral policy that charges passengers for the number of seats they occupy and are thereby unavailable to be sold to other customers. By the same token, it would not be discriminatory against parents to charge for two seats even if a toddler ends up in her parent's lap, instead of the seat purchased for her, during the entire flight. The charge for two seats merely reflects the lost opportunity to sell the child's seat to another customer. The reason for the differential treatment is about the number of seats, not about health status.

Similarly, in personal injury, or tort, law, we explore examples of unhealthy defendants who have injured another person by transmitting a contagious disease or who have performed a duty – such as medical treatment – with a health impairment. If those defendants are held liable for the harms that they inflict, one could say that they are treated unfavorably based on their health statuses. On the other hand, one could argue that they are being held to the same standard of care as a healthy person and fall short of that standard by failing to take reasonable precautions. The reason for the verdict in favor of the plaintiff is, therefore, not about the defendant's health status but her failure to exercise reasonable care under the circumstances. Recall that we include not only intentional, but also disparate impact discrimination in our definition. We explain whether, and why, some of these facially neutral examples nevertheless are healthist in Chapter 5.

Readers may also balk at including certain activities, in particular, smoking, as prohibited bases for discrimination. Our definition would seem to protect an adult engaged in a habit linked to a variety of serious health conditions for the individual and those around her, just as it would cover a child diagnosed with type 1 diabetes. Are we prepared to defend a civil rights law for smokers? Many may readily agree that the child should not be denied a health insurance policy or access to blood-sugar monitoring equipment. But should smokers receive similar protection? The short answer is – sometimes. We do not propose across-the-board legal protections for smokers but conclude that certain anti-smoking policies and laws are healthist. Specifically policies that are based on animus or unfair stereotypes, unduly infringe on private conduct,

fail to improve health or promote healthier choices, reduce access to health care, or deepen disparities are normatively wrong and, therefore, healthist.

This discussion demonstrates that our approach to healthism is fluid. That fluidity may strike some readers as unworkable and hopelessly indeterminate. Stigma and stereotypes are social constructs that may change over time. Could a policy that is healthist today not be so tomorrow? Some of our factors turn on whether a particular law, policy, or practice is effective. Does smoking, in fact, decrease when taxes on tobacco products are increased? Must we then wait for scientific testing of that question before clearing the policy as non-healthist?

We recognize these and other challenges with applying our rubric, but we emphasize that what we offer are guideposts and factors for consideration, not a definitive, one-size-fits-all remedy. Our flexible framework is akin to the reasonable care standard in the law of negligence. Under tort law, a defendant may be deemed negligent, and therefore liable for injuring another, if she fails to exercise reasonable care under the circumstances. What counts as reasonable care, however, may be different from one place and time to another. Moreover, some formulations of reasonable care turn on a cost-benefit analysis, comparing the cost of prevention to the quantum of safety gained. Those elements may also change with new science and new technology, just as our conclusions about the health effects of various strategies to reduce tobacco usage may change. Nevertheless, courts and juries can – and do – draw conclusions about what constitutes reasonable care under the circumstances. The broad contours of tort law provide guidance for other actors aiming to conduct themselves in such a way to avoid liability. Similarly, we believe that our flexible approach to healthism will provide guidance to government and private actors seeking to avoid acting in healthist ways. To be sure, healthism is a complex, multilayered concept.

2

Understanding Healthism

2.1. INTRODUCTION

In Chapter 1 we considered both the reasons for and the major objections to recognizing healthism as a form of discrimination. While healthism can lead to a number of social ills, there are still many good reasons to differentiate based on health status. Must we forgo those potential benefits to avoid the potential harms? We respond with a resounding: "No."

As we explore in Chapters 3–5, current legal protections leave much socially undesirable healthism unaddressed. Yet we do not want to discount the value of some health-status differentiations. To that end, we believe it is possible to distinguish between "good" (or socially desirable) health-status distinctions and "bad" (or socially undesirable) health-status discrimination.

With respect to the "good" category, we recognize that health-status differentiations can generate welfare or utility, facilitate healthy decision-making, reduce health risks, lower costs, and lead to better health care and increased access. When individuals have the ability to make meaningful choices about their health and health care, distinguishing on the basis of health can actually have a positive impact. Namely, health-status differentiation can create incentives for people to improve their own – as well as society's – health.

"Bad," or healthist, distinctions can have serious negative consequences. Healthist laws and policies may be the result of animus, rather than thoughtful, evidence-based policymaking. Moreover, even if not motivated by animus, healthism can express a view that people who are unhealthy have lower social value, leading to stigma. Healthism can also worsen health outcomes and create or perpetuate health disparities. It can punish people for their private conduct. It can even impede access to health care or undermine the ability to make healthy decisions.

In this chapter, we provide a theoretical framework for distinguishing socially beneficial health-based differentiations from socially damaging healthism. This chapter describes the guiding principles underlying these subtle distinctions. In Chapter 6, we apply these principles to a working paradigm, testing it against discrete examples. In broad-brush terms, if distinguishing based on health actually improves health, lowers costs, and reduces disparities, it would be hard to judge that conduct as healthist, at least by our definition. Our approach permits and encourages health-status distinctions that promote wellness, healthy decision-making, and access to health care. On the other hand, our approach discourages health-status differentiations that are based in animus, create stigma, intrude on private conduct, limit access to health care, impede the ability to make healthier choices, generate poorer health outcomes, or exacerbate existing health disparities. When a health-status distinction neither harms nor helps, we remain neutral. But how are we to know the difference?

2.2. GUIDING PRINCIPLES

Our definition of healthism from Chapter 1 includes a normative wrong. In other words, a "healthist" law or policy must offend some core norm or value. We offer four governing principles to guide this analysis: (1) health welfare, (2) health liberty, (3) health equality, and (4) health justice. We do not attempt to rank these principles in terms of their relative importance.[1] To be sure, some people may believe that health liberty should always carry the day, while others may be strict health egalitarians. And certain circumstances may implicate one of these four principles over the others. If a particular practice violates *all* of these values, however, we can safely say that it is healthist. Likewise, if a health-status differentiation advances *all* of these values, that result is strong evidence that the policy is not only nondiscriminatory but also socially desirable. Of course, those examples are the easy cases; the hard cases are ones in which the guiding principles point in different directions. When these values conflict, the categorization as "healthist" or benign is less clear.

[1] It would appear that Cass Sunstein agrees with this type of approach to policymaking. *See* Cass R. Sunstein, *The Ethics of Influence: Government in the Age of Behavioral Science* 4 (Cambridge University Press, 2016) (explaining that "it is often possible to make progress by bracketing the deepest theoretical questions, and by seeing if some approaches compromise none of the values and can attract support from people who are committed to all of them, or who are uncertain of their relationship").

2.2.1. *Health Welfare*

One important consideration when distinguishing benign considerations of health status from socially damaging healthism is whether the health-based distinction benefits society as a whole. In other words, does it produce net social welfare?

Considering how something affects the common good is an example of one well-accepted form of welfarism: classical utilitarianism. The utility principle seeks to facilitate the greatest good for the greatest number. As Jeremy Bentham famously explained, an action is moral when its tendency to increase the community's happiness exceeds its tendency to lower the community's happiness.[2] Bentham further opined that the ability of a law or policy to generate utility is the "measure of the Government." For utilitarian welfarists, maximizing utility or welfare should be the ultimate goal of law- and policy-makers.

Conversations about welfare maximization frequently employ the notion of efficiency. While the utility principle describes how governments should function, efficiency captures the kinds of outcomes they produce. Utilitarians believe that regulations should put resources to their most efficient use: maximizing the benefit to society, while minimizing the costs. Cost-effectiveness is then a decidedly welfarist concern. A utilitarian view of tort law, for example, would impose liability only when the cost of additional precautions is cheaper than the amount of safety – or accident avoidance – to be gained. If we held people liable whenever they failed to take safety precautions, even when the amount of safety gained was relatively minimal, the result would be inefficient, wasting societal resources and, thereby, reducing overall social welfare. Accordingly, we do not require all cars to drive only twenty-five miles per hour. While that precaution might reduce the number and severity of automobile accidents, it would cost society in terms of other things we value, such as timely movement of goods and services, driving enjoyment, fuel efficiency, and time spent on other endeavors.

In the context of health, increasing social welfare might mean raising average life expectancies and improving quality of life, whereas minimizing costs would entail lowering risks and reducing expenditures. Thus, cost-effectiveness alone may not justify classification based on health status. With the relatively recent rise of neoclassical economics, monetary gain became a major criterion in the welfare calculus. Previously, utilitarians tended to focus on maximizing happiness and minimizing suffering.[3] Today, many welfarists look to whether a given

[2] Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation* 7 (Clarendon Press, 1907) (1789).

[3] James Fieser, *Moral Philosophy through the Ages* (2001), www.utm.edu/staff/jfieser/class/300.

policy satisfies a person's preferences to determine whether it enhances welfare.[4] The idea is that if each individual maximizes her own welfare, then, in the aggregate, social welfare will be maximized. But regardless of how you define welfare, other competing yet important values still exist. As we discuss later in this book, even welfare-enhancing health-status differentiations may raise concerns related to privacy, autonomy, equality, and justice.

Another important consideration in welfare analysis is externalities. Externalities are costs or benefits that affect third parties.[5] For example, a factory located close to a residential area may produce pollution that bothers the neighboring homeowners. That pollution is a negative externality.[6] The factory may be increasing its and consumers' welfare by producing goods that consumers desire and purchase, but the residential neighbors' welfare is reduced because of the pollution. Unhealthy behaviors also can impose negative externalities, as others may be forced to bear the costs of another person's health-related decisions. M. Todd Henderson has argued that employees who smoke impose externalities on their coworkers, in the form of either higher health insurance premiums or lower wages.[7] Smoking may impose further costs on the corporation and its shareholders through reduced productivity and higher health-care costs. These externalities produce inefficiencies and reduce overall social welfare. The goal, then, of law- and policy-makers is to make sure that we all fairly bear – or, in the words of economists, *internalize* – the costs that we create. The factory, for example, would need to pay the homeowners an amount that represents the value of the pollution-free air that they are giving up and incorporate that cost into the price of its product.[8]

Because individual preferences are frequently the modern measure of welfare, it would seem that laws or policies that ignore individual preferences would undermine welfare. Sometimes policies designed to promote health will be contrary to the individual's – at least short-term – wishes, making the intervention arguably paternalistic.[9] For instance, while a person might crave

4 *See* Connie S. Rosati, *Persons, Perspectives, and Full-Information Accounts of the Good*, 105 *Ethics* 296 (1995) (defining preferentism); *see also* Matthew D. Adler, *Happiness Surveys and Public Policy: What's the Use?*, 62 *Duke L.J.* 1509, 1511 (2013) (defending preferentism); Daniel Haybron, *The Pursuit of Unhappiness* 34 (Oxford University Press, 2010) (describing preferentism as "the theory to beat").

5 John Black, Nigar Hashimzade, and Gareth Miles, *Externality, A Dictionary of Economics* (Oxford University Press, 5th edn. 2017).

6 Mark Seidenfeld, *Microeconomic Predicates to Law and Economics* 63–4 (Lexis Nexis, 1996).

7 M. Todd Henderson, *The Nanny Corporation*, 76 *Univ. Chi. L. Rev.* 1517, 1518 (2009).

8 Ibid.

9 *See* Lindsay J. Thompson, Paternalism, in *Encycl. Bus. Ethics and Soc'y* 1 (Sage Publications, Inc., Robert W. Kolb ed., 2008) (explaining that paternalism infringes on autonomy with the intention of protecting or benefiting the individual).

a cupcake or a cigarette in a given moment, she would ultimately prefer to be a thinner nonsmoker in the longer term. A paternalistic policy could outright ban cupcakes or cigarettes or it might just increase the costs of eating baked goods or smoking in such a way that alters someone's short-term preferences in the name of moving her closer to the long-term goal of weight loss or smoking cessation.[10] Not surprisingly, given the popularity of neoclassical economics, welfarists tend to be anti-paternalistic, or at least they would limit paternalism to situations in which one's preferences could harm someone else, not merely oneself.[11] That view might justify requiring a person to be immunized, even against her will, but not to require her to lose weight.[12]

In certain cases, however, paternalistic interventions can generate real social benefit, consistent with welfarism. Consider the trend of "Tobacco 21" laws, which increase the legal age for buying tobacco products from eighteen to twenty-one years of age. While a nineteen-year-old might want to light up a cigarette, these laws would prohibit her from simply walking into a convenience store and buying a pack. To the extent that they undermine the preference of some young people to smoke, Tobacco 21 laws are paternalistic. Importantly, however, they do not make underage smoking *illegal*; they merely make it harder for anyone under the age of twenty-one to obtain cigarettes. Tobacco 21 laws are one example where the costs may be well worth the benefits. To start, we as a society do not value smoking highly, let alone underage smoking, and evidence shows that increasing the smoking age can reduce the smoking rate and the purchasing of cigarettes.[13] The long-term health benefits at both the individual and population levels would appear to outweigh any concerns about paternalism or short-term welfare loss experienced by the eighteen- to twenty-year olds who can no longer purchase tobacco products. In short, Tobacco 21 laws appear to increase net social welfare. In addition, such laws are potentially in the smoker's long-term best interest, even if against her short-term individual preferences.

But the devil is in the details. Simple predictions about how policies might affect individual behavior and social welfare may not play out as predicted. Take one particularly provocative study on the impact of cigarette taxes on

10 *See generally* I. Glenn Cohen et al., *Nudging Health: Health Law and Behavioral Economics* (Johns Hopkins University Press, 2016).

11 Richard A. Epstein, *In Defense of the "Old" Public Health: The Legal Framework for the Regulation of Public Health*, 69 *Brooklyn L. Rev.* 1421 (2004).

12 For a well-stated contrary view, *see generally* Lindsay F. Wiley et al., *Who's Your Nanny? Choice, Paternalism and Public Health in the Age of Personal Responsibility*, 41 *J.L. Med. & Ethics* 88 (2013), www.aslme.org/media/downloadable/files/links/j/l/jlme-41_1-wiley-supp.pdf.

13 Stephanie R. Morain, et al., *Have Tobacco 21 Laws Come of Age?*, 374 *N. Engl. J. Med.* 1601–4 (2016).

the federal budget. It found that cigarette taxes would reduce federal spending in the short term due to increased population health. In the long term, however, as people live longer, the tax might increase spending because the government will spend resources – in the form of federal retirement benefits and government health-care programs – on people who otherwise would have died prematurely from smoking-related issues.[14] If this study is correct and we adopt an economic definition of welfare, a cigarette tax might actually, over time, *decrease* social welfare. To put it in harsh cost-benefit terms, it could actually be more efficient for would-be smokers to conserve resources by dying as quickly and as cheaply as possible. A cigarette tax designed to discourage smoking might be paternalistic in the sense of being in an individual's best interest but not welfare-enhancing – at least in purely economic terms – for society as a whole. Of course, that is a bleak way to look at the world. Under a nonmonetary view of welfare, the cigarette tax could be considered welfare-enhancing because the individuals who do not die prematurely from smoking clearly obtain an individual benefit from living longer.

We can also consider two other notorious paternalistic policies, the Snooki tax and the Big Gulp ban.[15] The Snooki tax got its name when reality television star Nicole "Snooki" Polizzi asserted that the Affordable Care Act's 10 percent tax on indoor tanning was aimed at her personally.[16] The Big Gulp ban referred to a short-lived New York City law, enacted under Mayor Michael Bloomberg, which capped the sale of certain sugary beverages to sixteen-ounce servings.[17] Much as Tobacco 21 laws do not outright bar underage smoking, neither the tanning tax nor the portion control law actually removes a person's ability to patronize tanning salons or buy sugary drinks – they just make these activities more costly. The indoor tanning tax merely makes the activity more

[14] James R. Baumgardner et al., *Cigarette Taxes and the Federal Budget – Report from the CBO*, 367 N. *Engl. J. Med.* 2068–70 (2012).

[15] *See generally*, Jessica L. Roberts and Elizabeth Weeks Leonard, *What Is (And Isn't) Healthism*, 50 *Ga. L. Rev.* 833, 892–3, 903–6 (2016) (concluding that the Snooki tax "seems unlikely to affect the ability to make healthy choices, worsen health outcomes, or create health disparities," and that the Big Gulp ban does not clearly produce positive effects).

[16] 26 U.S. Code § 5000B; Robert Farley, *Snooki Says Obama Put a 10 Percent Tax on Tanning, Politifact* (June 21, 2010), www.politifact.com/truth-o-meter/statements/2010/jun/21/snooki/snooki-says-obama-put-10-percent-tax-tannning/; IRS, *Excise Tax on Indoor Tanning Services Frequently Asked Questions*, www.irs.gov/businesses/small-businesses-self-employed/excise-tax-on-indoor-tanning-services-frequently-asked-questions (last visited July 27, 2017).

[17] The New York Court of Appeals ultimately struck down the rule on administrative law grounds. *N.Y. Statewide Coal. of Hispanic Chambers of Commerce* v. *N.Y. City Dep't of Health and Mental Hygiene* (N.Y. June 26, 2014), www.nycourts.gov/ctapps/Decisions/2014/Jun14/134opn14-Decision.pdf; Haley Draznin, *NYC Loses Appeal to Ban Large Sugary Drinks, CNN* (June 26, 2014), www.cnn.com/2014/06/26/justice/ny-sugary-drink-rulling/index.html.

expensive, thus possibly nudging individuals away from engaging in it. Likewise, the New York law also did not ban consumption of larger amounts of sugary drinks, but it did make them more expensive and more difficult to obtain (e.g., one would have to buy two smaller drinks instead of one large one). In other words, these laws raise the costs of the unhealthy behavior, which could at some point price out certain individuals. It is worth noting that the effectiveness of these laws is far from clear.[18] But if we as a society do not view tanning or drinking sugary drinks as socially valuable activities, just a modest chance of improving health might be enough to justify the policy.

The Tobacco 21 laws, the Snooki tax, and the Big Gulp are relatively "soft" forms of paternalism, encouraging healthier choices while falling short of outright prohibiting unhealthy ones. And even though they might violate some individual preferences, there still may be a net welfare gain. Nevertheless, these policies may not be efficient long-term interventions. Tobacco 21 laws, the Snooki tax, and the Big Gulp ban do not educate the public about the health risks of nicotine use, UV exposure, and refined sugar.[19] Thus, while individuals could end up making healthier choices, those decisions may not translate into better decisions when confronted with opportunities to smoke electronic cigarettes, sun bathe at the beach, or eat an ice cream sundae.

Those three laws are government interventions. But private actors, including employers and businesses, may also adopt welfarist policies.[20] To be sure, they do not have the same coercive power as the state. Mainly, they cannot prosecute and incarcerate a person. Regardless, private actors can be powerful nannies. Employment in particular serves as a strong incentive. For example, the nicotine hiring bans from Chapter 1 encourage prospective employees to quit smoking. Additionally, as key providers of health insurance in the United States, employers can use their employee benefits to encourage certain behaviors or to discourage others.[21] Consider employer-provided wellness programs, which reward employees for things like agreeing to biometric testing, lowering cholesterol, losing weight, or quitting smoking. Although an employee can opt out, she arguably does so at a loss–first, because she will not receive the offered benefit and, second, because her employer may spend money on

[18] Jennifer Calfas, *Study: Fewer Adults Use Indoor Tanning Beds, USA Today*, (July 2, 2015), www.usatoday.com/story/news/nation/2015/07/01/indoor-tanning-decline-us-adults/29519255; Robert King, *Tanning Troubles: Fewer People Head Indoors to Seek Rays, Wash. Examiner* (July 28, 2015), www.washingtonexaminer.com/tanning-troubles-fewer-people-head-indoors-to-seek-rays/article/2569064.

[19] Roberts and Leonard, note 15, at 903–6.

[20] Ibid. at 892–3.

[21] Ibid. at 893.

those programs instead of raises or other amenities. Certainly, a worker who wants to avoid a wellness program could always look for another job. But as anyone who has been on a prolonged job hunt knows, it is often not that easy. Consequently, employers can be very effective regulators, especially when alternative, desirable employment is not easy to come by.[22]

In the past, welfarism has frequently rested on three key assumptions about how people behave. First, welfarists believe that people want to maximize utility through their actions.[23] Second, welfarists maintain that people respond rationally and predictably to incentives.[24] And third, welfarists view individuals as independent, rational actors who make decisions based on relevant, comprehensive information.[25] Yet these assumptions only get us so far. For one thing, behavioral economics acknowledges that people do not always act rationally but, rather, are influenced by implicit bias and other judgment errors.[26]

Moreover, restrictions on individual choice also undermine the rational actor model's theoretical foundations. A variety of factors – including but not limited to where a person lives, her income, education, work schedule, amount of leisure time, relationship status, caregiving responsibilities, ease of mobility or transportation, network of social support, and current health status – may impede the ability to make healthier choices.[27] Efforts to encourage healthy decision-making will inevitably fail if a person lacks meaningful choices. The literature on social determinants of health explains that interventions focused on individual lifestyle changes can backfire if the targeted populations are unable, for the reasons noted above, to make the desired changes. For example, charging smokers more for their health insurance is designed to create an incentive to quit, while potentially offsetting the costs of smoking-related health conditions. But at least one study showed that tobacco surcharges had little effect on smoking cessation but rather resulted in lower insurance uptake by smokers.[28] While it may be rational to quit smoking (for reasons including but not limited to health insurance premiums), people did not respond favorably to the insurance surcharge.

[22] Ibid.

[23] E. Roy Weintraub, *Neoclassical Economics, in The Concise Encyclopedia of Economics* (The Library of Economics and Liberty, 2007).

[24] Ibid.

[25] Ibid.

[26] *See generally Behavioral Law & Economics* (Cass R. Sunstein, ed., 2000).

[27] Wendy K. Mariner, *Beyond Lifestyle Governing the Social Determinants of Health*, 42 *Am. J. L. & Med.* 284 (2016), http://journals.sagepub.com/doi/pdf/10.1177/0098858816658268.

[28] Abigail S. Friedman et al., *Evidence Suggests That the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation*, 35 *Health Affs.* 1176 (2016).

Additionally, incentives do not always work the way that law- and policymakers want. When the French colonized Vietnam, they discovered a serious rat infestation in Hanoi.[29] Thinking that they could get the villagers to do the work for them, the French colonial government decided to offer a bounty for every rattail that a person turned in. That is, they designed an incentive system to encourage the trapping and killing of rats. Or so they thought. Instead of leading the villagers to exterminate the pesky vermin, it led the villagers to farm them. The bounty created an unexpected market for rattails, which people filled by raising rats. When an incentive for one thing – like killing rats – has an unanticipated or undesirable effect – like farming rats – economists call that a perverse incentive. Perverse incentives can also occur when law- and policymakers attempt to encourage healthy behavior. We can return to the tobacco surcharge in health insurance. The idea behind the tobacco surcharge was to encourage people to quit smoking by imposing an additional financial burden. For some people, however, the added costs created a perverse incentive. Instead of forgoing *tobacco*, people who were faced with significant financial penalties decided to forgo *health insurance*.[30] Perverse incentives could then undermine even well-intentioned health-status differentiations.

Finally, intervening values like equality, autonomy, privacy, and social justice may render even welfare-generating distinctions based on health status problematic. Imagine that the tobacco surcharge saves insurance companies significant sums of money, resulting in a large net welfare gain, despite a markedly negative effect on the less than 17 percent of Americans who still smoke. Demographically, smokers have lower education and lower income and are disproportionately either multiracial or Native American.[31] They also face widespread social stigma.[32] The law, while improving overall societal welfare, would significantly reduce the welfare of already-disadvantaged populations. Importantly, looking only to net welfare does not tell us whom a policy might harm. In other words, welfarism notoriously neglects distributional concerns.[33]

[29] Robert Peckham, *Epidemics in Modern Asia* 114 (Cambridge University Press 2016); Michael G. Vann, *Of Rats, Rice, and Race: The Great Hanoi Rat Massacre, an Episode in French Colonial History*, 4 *French Colonial History* 191 (2003).

[30] Abigail S. Friedman et al., *Evidence Suggests That the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation*, 35(7) *Health Affs.* 1176, 1181 (2016).

[31] Brady Dennis, *Who Still Smokes in the United States – In Seven Simple Charts*, *Washington Post* (Nov. 12, 2015), www.washingtonpost.com/news/to-your-health/wp/2015/11/12/smoking-among-u-s-adults-has-fallen-to-historic-lows-these-7-charts-show-who-still-lights-up-the-most/?utm_term=.ac7981009d8e.

[32] Jessica L. Roberts and Elizabeth Weeks Leonard, *Stigmatizing the Unhealthy*, 45 *J.L. Med. & Ethics* 484 (2017).

[33] *See* Martha C. Nussbaum, *Capabilities & Human Rights*, 66 *Fordham L. Rev.* 273, 281 (1997) (explaining that utilitarianism does not tell us "who has got the money, and whether any of it is mine").

If you care about equality, in particular, you might not want policies to single out certain populations based on animus or negative stereotyping. Alternatively, if you care about liberty, you may not want the government coming in and policing your private conduct regardless of whether that policing is for your – or society's – good. Finally, if you care about justice, you may not want economically or socially disadvantaged populations to bear the brunt of the burden of a welfare-generating initiative. Even the most well-intentioned, rational health-status differentiations can also be harmful if they intrude too deeply into our private lives (health liberty), create or perpetuate stigma (health equality), or exacerbate health disparities (health justice). Because of these complexities and contradictions, understanding and regulating healthism demands a broader theoretical framework. We therefore cannot rely on welfare alone, including in cases where it promotes other important values.

2.2.2. *Health Liberty*

The effect that differentiation based on health status has on liberty is another important consideration when determining whether the law or policy is healthist. Health is highly personal. Too much oversight, whether from public or private entities, could limit choices in a way that infringes on our much-treasured personal freedoms. The United States has enshrined this core liberty value in the Constitution. The first ten Amendments, constituting the Bill of Rights, were added to the Constitution in response to states' calls for greater protection for individual liberties. Notably, the Amendments limit governmental power. The Bill of Rights is a charter of "negative" rights, specifying what the government cannot do to us; it does not include "positive" rights, requiring any particular benefits or services that the government must bestow upon us.[34]

The notion that third parties – particularly the government – should not impede our choices invokes John Stuart Mill's liberty principle, also known as the "harm principle." It holds that impeding liberty is only appropriate to prevent harm to others.[35] According to that reasoning, regulators can tell me not to hurt my neighbor, but I should be free to engage in self-destructive behavior

[34] *See* Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 *U. Pa. J. Const. L.* 1325, 1331–2 (2010).

[35] John Stuart Mill, *On Liberty and Utilitarianism* 12 (Alfred A. Knopf, Inc., 1992) (1859); *see also* Jessica L. Roberts, *Rethinking Employment Discrimination Harms*, 91 *Ind. L.J.* 393, 417 (2016). Modern libertarians include Friedrich Hayek and Robert Nozick. *See* Friedrich Hayek, *Law Legislation and Liberty* (University of Chicago Press 1976); Robert Nozick, *Anarchy, State, and Utopia* (Basic Books, Inc. 1974).

if I wish.[36] For example, the government can infringe on my liberty to prevent my spreading a contagious disease, but it cannot prevent me from getting the disease myself. Strong libertarianism rejects paternalism of any kind.

Liberty also includes notions of privacy and autonomy. Privacy connotes a "right to be left alone."[37] It allows us to make choices free from public scrutiny.[38] While counterintuitive, privacy is also essential to our relationships.[39] You probably share things with your romantic partner that you would not want to tell your employer. It is privacy that allows you to draw those lines between the secrets you share and the secrets you guard closely. Autonomy describes the ability to make free and independent choices.[40] Autonomy is what gives individuals the ability to live the kind of lives they want. Exercising autonomy, then, requires personal liberty. To make unencumbered choices, we must have the freedom to act.

Privacy and autonomy are, thus, related concepts. Both involve maintaining a certain degree of control over our lives. Policies that differentiate on the basis of health status could threaten both of these core American values. Decisions about how to treat our bodies – including what foods we eat, how much we sleep, the people with whom we have sex, whether we practice yoga or go to CrossFit – are all incredibly intimate.[41] Efforts to change those behaviors both intrude into our private lives and limit our access to free choices.

A law or policy might violate liberty in a variety of ways. It could punish people for private conduct that has no harmful effect on others. It could also cut off resources or otherwise reduce the ability of people to make healthy choices. Healthism could then encroach too deeply into our private lives or could jeopardize our personal freedom.

Consider the bans on hiring nicotine users. Employers are free to adopt tobacco-free workplaces. That is, they can forbid their employees from using tobacco products on the job. A ban on nicotine use is more expansive. It bans more conduct (tobacco versus nicotine) and extends beyond working hours. A person who might want to smoke a pipe (or even use a nicotine patch) in the privacy of her own house during off hours would violate the policy. The nicotine ban at once intrudes on privacy, by following the employee home,

[36] Roberts, note 35, at 417.

[37] Samuel D. Warren and Louis D. Brandeis, *The Right to Privacy*, 4 *Harv. L. Rev.* 193, 193 (1890).

[38] David Orentlicher, *Genetic Privacy in the Patient-Physician Relationship*, in *Genetic Secrets: Protecting Privacy and Confidentiality in the Genetic Era* 77, 78 (Mark Rothstein, ed., Yale University Press 1997).

[39] Charles Fried, *Privacy*, 77 *Yale L. J.* 475, 477 (1968).

[40] Gerald Dworkin, *The Theory and Practice of Autonomy* 3–5 (Cambridge University Press 1988).

[41] Roberts and Leonard, note 15, at 891.

and restricts her liberty, by forcing her to choose between using nicotine and having employment. One might then object to certain healthist policies on libertarian grounds by asserting that they both intrude into the private sphere and limit personal freedom. The lifestyle discrimination statutes described more fully in Chapter 3 purport to protect against "discrimination." However, they are libertarian legislation masquerading as egalitarian.

Yet not all health-status differentiations violate liberty. In fact, some distinctions might actually *promote* liberty by empowering individuals with opportunities and resources to make healthier choices. For example, some employers offer a range of amenities, including on-site health clinics and services, fitness centers, and prescription drugs at little to no cost.[42] These policies give people more options related to their health than they would otherwise have. Although smoking cessation programs explicitly target people based on a health-related factor, namely, smoking status, they offer an opportunity to quit that a smoker might not otherwise have. Distinctions that actually increase personal freedom are not healthist.

Before moving on to the next governing principle – health equality – a quick note about autonomy. Both health welfare and health liberty seem to proceed from the assumption that individuals possess full autonomy. In other words, welfarists and libertarians tend to assume that people are capable of making independent, autonomous decisions. At first blush, those assumptions may make laws or policies that are actually healthist seem unobjectionable. For instance, a welfarist or a libertarian could maintain that if I do not want employers to reject my job application because I am a smoker, I should either respond to the incentive or decide to quit. Of course, anyone who has actually tried to adopt healthier behaviors can attest to the difficulty of breaking a bad habit.[43]

Moreover, the ability to successfully achieve a desired health outcome may not rely solely on individual behavior. Our DNA, which is largely determined before birth and outside of our immediate control, affects personal health in numerous ways. Research has linked genetics to a person's propensity to gain weight.[44] Additionally, body chemistry and other physiological conditions,

[42] Jessica L. Roberts and Leah Fowler, *How Assuming Autonomy Undermines Wellness Programs*, 27 *Health Matrix* 101, 121–23, (2017).

[43] Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 *Iowa L. Rev.* 571, 615 (2014) (citing Wendy K. Mariner, *The Affordable Care Act and Health Promotion: The Role of Insurance in Defining Responsibility for Health Risks and Costs*, 50 *Duq. L. Rev.* 271, 301 (2012); Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform – Problems with Wellness Incentives*, 362 *New Eng. J. Med.* e3(1), e3(1) (2010) [citing the failure of diets to achieve long-term weight loss even though dieters want, and try, to lose weight]).

[44] *See* Anthony P. Goldstone and Philip L. Beales, *Genetic Obesity Syndromes*, 36 *Obesity and Metabolism* 37 (2008).

genetic or not, may impact a person's weight.[45] Thus, tempting as it may be to blame someone for being overweight, what she weighs may not be totally within her control.[46] Similarly, individuals may be genetically or psychologically predisposed to addictions of various types. Genetics clearly play a role in the incidence of heart disease, diabetes, cancer, and a host of other conditions, regardless of how much a person controls her diet, exercise, stress, and living conditions.

Beyond our genetics and physiology, all kinds of external factors also affect the decisions we make. What very well may have started as a purely voluntary decision could balloon into an undesirable and difficult-to-change situation. Life is inevitably path-dependent. While I might have thought smoking made me look cool and grown-up at age fifteen, by the time I am thirty years old, and seriously addicted, the decision to light up may feel less voluntary.[47] The physiological effects of addiction are now well-known and certainly belie any suggestion that smoking is entirely voluntary. In fact, most smokers would like to quit.[48] And, as many of us know too well, a person may fail to lose weight despite her genuine intent and best efforts. Making matters worse, the more weight a person gains, the more effort it requires to reach a healthy body mass index (BMI), leaving more opportunities for stumbling blocks and challenges.[49] How accountable do we want people to be for unhealthy decisions made at different times, or under different circumstances, in their lives? Is it fair to continue to punish people for something that they sincerely wish they had never done in the first place?

Those questions point to a broader tension regarding what we deem "voluntary." Surely, someone who refrains from certain activity when a gun is held to her head is not acting voluntarily. But there are varying degrees of duress. In the narrowest sense, we could say that a person is acting under duress when responding to a threat created by someone else. But what if the person is put to a hard choice because of conditions or circumstances of her own making? In a classic torts case, an employee who painted the wooden handles of hatchets notified his employer that the drying racks for the tools tend to vibrate because

[45] *What Causes Overweight and Obesity?*, National Heart, Lung, and Blood Institute, www.nhlbi.nih.gov/health/health-topics/topics-obe-causes (last visited May 28, 2016).

[46] Roberts and Leonard, note 15, at 843.

[47] Roberts, note 43, at 614–15.

[48] Ibid. at 615 (citing Ann Malarcher et al., *Quitting Smoking among Adults – United States 2001–2010*, 60 *Morbidity & Mortality Wkly. Rep.* 1513, 1513 (2011), www.cdc.gov/mmwr/pdf/wk/mm6044.pdf).

[49] Jennifer Bennett Shinall, *Intersectional Complications of Healthism*, 18 *Marquette Benefits & Social Welfare L. Rev.* 255–77 (2017).

of their proximity to other mechanical equipment in the shop.[50] The vibration caused hatchets to fall off the racks onto the employee's workspace, threatening to cut off his fingers. The employer essentially responded: "Use the racks or leave." The case, which took place before workers compensation laws and the modern doctrine of assumption of risk, held that the employee's decision to stay on the job was voluntary. Therefore, he could not sue if he ended up losing a finger. But should it matter whether the employee had a family to support and no other possible employment? Or if he lacked reliable transportation to another, more remote employer? What if all hatchet factories had a similar arrangement, as a matter of industry custom?

Not having access to certain resources can also impair autonomy. For example, poverty or proximity to grocery stores, parks, and urban violence may limit a person's ability to eat fresh fruits and vegetables, to exercise regularly, or to get adequate sleep.[51] Imagine a single parent who is the sole breadwinner for a family with several children. She must work two jobs to make ends meet, leaving her little time for rest or relaxation. Because of limited housing options, she lives in a low-income neighborhood in the inner city. Her neighborhood – while full of fast food restaurants and convenience stores – lacks traditional grocery stores that sell fresh produce. Imagine it is also poorly lit in the evening and has no green spaces where she can take her children to play for free. Gunshots and other crimes are prevalent, thus further limiting her willingness to venture out of the house. If one of her employers offered her a break on her health insurance premium for losing weight or for lowering her blood pressure, no matter how enticing the incentive, the single parent still would have substantially more difficulty meeting those goals than a married person in a two-income household with no children who lives on a quiet, suburban, residential street or in an urban high-rise with a workout facility and Whole Foods down the block. In short, a person's unhealthy "choices" may in fact be largely outside of her individual control.

Because we recognize that autonomy is not a given but rather aspirational,[52] when we consider health welfare and health liberty we are conscious that some individuals may not have access to the full complement of healthful choices. As such, we support laws and policies that create the opportunity for making healthy choices and recognize that poor health may be the result of myriad factors beyond a person's immediate control.

[50] *Lamson* v. *Amer. Axe and Tool Co.*, 58 N.E. 585 (Mass. 1900).

[51] Roberts and Leonard, note 15, at 893; *see also* Martha Albertson Fineman, *The Autonomy Myth: A Theory of Dependency* 10, 30 (The New Press 2004); Roberts and Fowler, note 42, at 116–21.

[52] Fineman, note 51.

2.2.3. *Health Equality*

Health equality is another important consideration when determining whether a law or policy is healthist. This governing principle provides that all Americans are entitled to equitable, nondiscriminatory treatment with respect to their health. To be sure, there are several reasons why an employer might choose not to hire smokers that have nothing to do with animus or social stereotyping, like increased costs or a desire to encourage people to be healthy.[53] But an employer also might choose not to hire smokers simply because its management does not *like* smokers or believes that smokers are lazy or would undermine the company culture.[54] To single out a person based on her health status, because of an aversion to people perceived as unhealthy, or because of their lowered social value, offends health equality.

The norms underlying health equality are equitable treatment and dignity. Scholars and philosophers have long asserted that human beings have inherent value and deserve to be treated with dignity. Immanuel Kant was clear that people are not a means to an end, but rather an end unto themselves.[55] Therefore, you cannot put a price on human existence. Kant explains, "the sole condition under which anything can be an end in itself has not mere relative worth, i.e., a price, but an inner worth, i.e., dignity."[56] While a welfarist might define value in economic terms, Kant is clear that you cannot put a price on dignity, nor compare it to other values.[57] That is not to say that our approach to healthism will always rank equality above other concerns, but rather that it acknowledges the significance of dignity and the potential for equality to conflict with other guiding principles.

Thus, underlying the health equality principle are the premises that human beings possess dignity and that dignity is priceless. We deserve to be treated equally because we are all equally valuable. Treating a person or group of people worse than their peers offends their dignity by ignoring their inherent value. Thus, acting based on animus or stigma denies our human dignity and is un-egalitarian.

[53] Roberts, note 43, at 579–80.

[54] Ibid. at 584–6.

[55] Immanuel Kant, *Groundwork of the Metaphysic of Morals*, H. J. Paton, trans., 28–29 (Harper Textbooks, 1958) ("[Persons] are objective ends, i.e., things whose existence is an end itself. It is indeed an *irreplaceable* end: you can't substitute for it something else to which it would be merely a means.")

[56] Immanuel Kant, *Groundwork of the Metaphysics of Morals*, in *Justice: A Reader* 183–4 (Oxford University Press, Michael. J. Sandel, ed., 2007).

[57] Ibid. ("[D]ignity is, infinitively above all price, with which it cannot be brought into comparison or computation without, as it were, violating its holiness.")

Egalitarian concerns are most readily associated with antidiscrimination law. Prohibiting discrimination on the basis of race, sex, age, disability, and genetic information certainly seeks to promote equality. The egalitarian impulse, however, arguably goes beyond the traditional kinds of civil rights laws outlined in Chapter 3 to include insurance law and even torts and contracts. The notion is that similarly situated people should be treated similarly. A woman should not be denied the ability to enter a binding contract or receive a lower tort award than a man simply because of her sex. Perhaps someone who uses tobacco should not pay more for health care than someone who races motorcycles. It is worth being attuned to the possibility that law and policy are animated by underlying animus or stigma. Federal health insurance laws single out tobacco users, allowing insurance companies to charge them up to 150 percent higher premiums than nonusers, but disallow similar discrimination against others with poor health histories, risks, or habits. Is that because the public and law-makers harbor animus toward or stigma against smokers but not motorcyclists?

Human cognitive functions – the same kind of functions that undermine the rational actor model – may lead people to disfavor certain groups or individuals, even when they do not intend to discriminate. While the rat farmers of Hanoi might have been a little too rational for their colonial overlords' good, we know that people do not always act rationally. Far from calculating each of our actions from a blank slate, human cognitive function relies on any number of shortcuts.[58] For instance, human beings appear hardwired to categorize – our brains tend to group like things together.[59] Simplifying the world through categorization allows us to function. The first time you saw a dog, you probably thought: "What is that?" But once you got used to seeing dogs, you figured out that whether you were looking at a Great Dane or a Chihuahua, you were looking at a dog. That means that, even if you have never seen an Alaskan Klee Kai, if you ever meet one, you will not think: "What is that?" You will think: "Oh look, a kind of dog that I have never seen before." Our brains' ability to categorize protects us from information overload. Life would be exhausting and unmanageable if every time

[58] *See*, e.g., Cass R. Sunstein, *Introduction in Behavioral Law and Economics* 3–7 (Cass R. Sunstein, ed., 2000) (describing various cognitive biases that qualify for strict rational actor model).

[59] Jessica L. Roberts, *Protecting Privacy to Prevent Discrimination*, 56 *Wm. & Mary L. Rev.* 2097, 2116 (citing Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 *Stan. L. Rev.* 1161, 1164 (1995); Martha Minow, *Making All the Difference: Inclusion, Exclusion, and American Law* 7 [1990]).

we encountered something new we had to start from scratch. Like the word "discrimination," the word "stereotyping" has both neutral and pejorative connotations.[60] In the neutral sense, stereotyping simply means grouping like things together and making generalizations about their similar or dissimilar attributes. Used in this way, stereotyping makes our brains more efficient and protects us from getting overwhelmed by all the cognitive stimuli we all encounter on a daily basis.

From an equality perspective, however, problems arise because once we categorize things, we may develop preferences and beliefs surrounding those categories. Those stereotypes can be accurate or inaccurate, positive or negative, or value-neutral. Regardless, they can affect our cognitive functioning in both conscious and unconscious ways. For example, if I know I prefer cats to dogs, when I go to an animal shelter I will intentionally select a cat. Even if I do not consciously prefer cats to dogs, I may have beliefs about pet ownership, perhaps that dogs are more work than cats and require more space. Thus, when confronted with equally adorable kittens and puppies, I might select a kitten based on my belief that cats are lower maintenance than dogs, and not based on my preference for cats over dogs. The belief that dogs are higher maintenance than cats is a stereotype, even if it is true. Stereotypes can shape cognitive processes at the unconscious level.[61]

Now consider a more socially problematic example. Imagine the stereotype that men are more assertive than women. A person who holds that stereotypic belief might be more likely to put men in positions of power. A supervisor might then consciously promote Dave over Regina based solely on the stereotype. That decision would be an example of a *conscious* bias. Now assume that the supervisor wants to promote based on merit. Dave and Regina make equal contributions at team meetings. Yet the supervisor might be more inclined to notice and remember Dave's contributions – because they confirm the preexisting belief that men are assertive – than to notice and remember Regina's. Because the supervisor is more cognitively aware of Dave's contributions, the supervisor may then genuinely believe that the decision to promote Dave over Regina is based on merit and not on a stereotype about male assertiveness.

These hypotheticals raise an important point. While some discrimination occurs intentionally, people may unconsciously rely on stereotypes. This

[60] Ibid. at 2117 (citing Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 *Stan. L. Rev.* 1161, 1164 [1995]).

[61] Ibid. at 2142 (2015) (citing Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 *Stan. L. Rev.* 1161, 1164 [1995]).

cognitive phenomenon is called *unconscious* or *implicit* bias.[62] People are frequently surprised to learn of their own implicit biases.[63] Implicit bias tests are widely available[64] and have appeared in social and popular media.[65]

A significant amount of discrimination follows a common process. To discriminate – either consciously or subconsciously – a person must first recognize some kind of meaningful difference.[66] When we meet our new best friend's pet, we access all kinds of previously obtained information and past experiences that help us distinguish dogs from cats.

Yet for differentiation to move to discrimination (at least the pejorative, or "bad," kind of discrimination), the discriminator must attach a value to the difference.[67] It is one thing for me to say that cats are different from dogs. Imagine, however, that I identify as a cat person. Once a preference emerges, I move from acknowledging difference to attaching value. Instead of just merely saying that cats and dogs are different, I now express the position that cats are somehow – at least in my opinion – better than dogs. Value assignment is typically the second step in the process of discrimination. When I act on that preference, I am discriminating. Therefore, we can think of many kinds of discrimination as occurring in three identifiable steps: (1) differentiation, (2) value assignment, and (3) discriminatory acts (Figure 2.1).[68]

This three-part process captures both intentional and unintentional discrimination. As noted, if I believe that cats are superior animals, I have quite clearly differentiated between dogs and cats (step 1) and consciously assigned a value (step 2 – conscious). And even if I have no preference for cats over dogs, I might unconsciously believe the stereotype that dogs require more time and space, making cats preferable if I live in a small apartment and have a full-time

[62] Linda Hamilton Krieger, *The Content of Our Categories: A Cognitive Bias Approach to Discrimination and Equal Employment Opportunity*, 47 *Stan. L. Rev.* 1161, 1165, 1188 (1995); *see also* Tristin Green, *Discrimination in Workplace Dynamics: Toward a Structural Account of Disparate Treatment Theory*, 38 *Harv. C.R.-C.L. L. Rev.* 91, 95 (2003); Melissa Hart, *Subjective Decisionmaking and Unconscious Discrimination*, 56 *Ala. L. Rev.* 741, 745 (2005); Christine Jolls and Cass R. Sunstein, *The Law of Implicit Bias*, 94 *Calif. L. Rev.* 969, 975 (2006); Jerry Kang and Kristin Lane, *Seeing Through Colorblindness: Implicit Bias and the Law*, 58 *UCLA L. Rev.* 465, 467 (2010); Susan Sturm, *Second Generation Employment Discrimination: A Structural Approach*, 101 *Colum. L. Rev.* 458, 460 (2001).

[63] *See* Christine Jolls and Cass R. Sunstein, *The Law of Implicit Bias*, 94 *Cal. L. Rev.* 969, 975 (2006).

[64] *See*, e.g., Project Implicit, https://implicit.harvard.edu/implicit/takeatest.html (last visited Aug. 1, 2017).

[65] American Psychological Association, *Adoption of Implicit Bias Tests Is "Hasty,"* www.apa.org/monitor/2016/12/policing-sidebar.aspx; www.bbc.com/news/magazine-40124781.

[66] Roberts, note 59, at 2116.

[67] Ibid. at 2117.

[68] Roberts, note 59, at 2118.

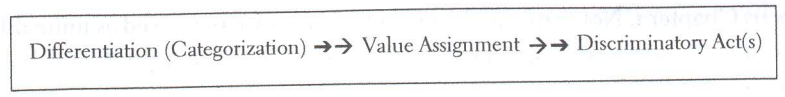

FIGURE 2.1. *Process of discrimination*

job (step 2 – unconscious). While not based on a clear preference, I am valuing cats over dogs given my circumstances. When I select a cat for either conscious or unconscious reasons I am making a discriminatory choice (step 3).

While the three-part process of discrimination applies to both conscious and unconscious bias, it does not capture certain types of unintentional discrimination. Specifically, it does not apply to disparities that result from structural factors rather than individual decision-making. For example, an airline that requires pets in carry-on cases to be under a certain weight would favor cats – which tend to weigh less than most dogs – but not because of any explicit or implicit value judgment about the desirability of cats versus dogs. By the same token, a job that has minimum height or lifting requirements might tend to favor male applicants over females, but not because of any value judgment about women. While certain laws – like the Americans with Disabilities Act – may prohibit structural discrimination, policies that have a disparate impact would not be clearly anti-egalitarian, at least by our definition. They might, however, raise justice-related concerns.

We shift now from pets and gender to health. People also have stereotypic beliefs related to health status. Americans tend to put a premium on health and wellness. People who are considered healthy benefit from any number of positive stereotypes. They are regarded as more attractive, more competent, and more worthy of trust.[69] With respect to poor health, our culture emphasizes the role of personal responsibility over socioeconomic or biological factors.[70] It is not uncommon, then, to blame the sick person for her lot in life[71] – the view that Representative Mo Brooks expressed in the quote that

[69] Roberts, note 43, at 585.

[70] Robert Steinbrook, *Imposing Personal Responsibility for Health*, 355 *N. Engl. J. Med.* 753 (2006) (defining the concept of personal responsibility and recognizing that the United States government promotes personal responsibility for health); D. B. Resnik, *Responsibility for Health: Personal, Social, and Environmental*, 33(8) *J. Med. Ethics* 444 (2007) ("Although individuals should play an important role in maintaining their own health, they should not be held entirely responsible for it . . . . [There] are many other ways in which societies can promote health, such as through sanitation, pollution control, food and drug safety, health education, disease surveillance, urban planning and occupational health.")

[71] Steinbrook, note 70, at 753 (citing a national survey in which 53 percent of Americans thought it was "fair" to ask people with unhealthy lifestyles to pay higher insurance premiums and higher deductibles or copayments for their medical care than people with healthy lifestyles).

opens Chapter 1. Not surprisingly, individuals who are perceived as unhealthy, like smokers and overweight people, must deal with stereotypes that they are unattractive, incompetent, and without self-control.[72] Notoriously, President Donald Trump repeatedly has revealed stereotypes about weight, for example, disparaging former employee and Miss Universe for gaining weight after being crowned, charging that she "is somebody that likes to eat" and was a "real problem" for contest officials.[73] Even physicians are not immune from these biases. Research shows that doctors tend to undertreat chronic pain, in part due to stereotypes about pain-management patients being addicts.[74] Physicians may also fire patients, believing them to be noncompliant, when the failure to follow the doctor's orders may be due to a lack of understanding or resources.[75]

Stereotypes about health status can lead to animus and stigma. Animus typically means a deeply held – and often irrational – prejudice.[76] Antidiscrimination scholar Elizabeth Emens has explained that "[a] person discriminates based on animus if she treats someone differently because of dislike or hostility towards the protected class of which that person is a member."[77] An employer might adopt a nicotine ban for paternalistic reasons because she wants to provide an incentive for people to quit smoking. Yet an employer could adopt the same policy simply because she despises smokers and thinks they are bad people. Animus therefore speaks to motivation, not to outcome. Courts have been willing to outlaw even rational discrimination based on animus.[78]

Similarly, stigma connotes strong disapproval at a social level. Stigmatization occurs in four steps: (1) acknowledging difference, (2) associating that difference with negative characteristics, (3) classifying people based on

[72] Roberts, note 43, at 585; *see also* Jessica L. Roberts and Elizabeth Weeks Leonard, *Stigmatizing the Unhealthy*, 45 *J.L. Med. & Ethics* 484 (2017).

[73] Jenna Johnson, *Trump Attacks Former Miss Universe Who "Gained a Massive Amount of Weight" and Had "Attitude,"* *Washington Post*, Sept. 27, 2016, www.washingtonpost.com/news/post-politics/wp/2016/09/27/trump-attacks-former-miss-universe-who-gained-a-massive-amount-of-weight-and-had-attitude/?utm_term=.07c1c0a1139e.

[74] *See* Kelly K. Dineen, *Moral Disengagement of Medical Providers: Another Clue to the Continued Neglect of Treatable Pain?* 13 *Hous. J. Health L. & Policy*, 163, 189–198 (2013).

[75] Jessica Mantel, *Refusing to Treat Noncompliant Patients Is Bad Medicine*, 39 *Cardozo* Law Rev. 127 (2018).

[76] *See generally*, Susannah W. Pollvogt, *Unconstitutional Animus*, 81 *Fordham Law Rev.* 887 (2012) (describing the jurisprudential development regarding the meaning of the term "animus").

[77] Elizabeth Emens, *The Sympathetic Discriminator: Mental Illness, Hedonic Costs, and the ADA*, 94 *Georgetown L.J.* 399, 409 (2006).

[78] *Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 433, 450 (1985).

that difference, and (4) devaluing people based on the classification.[79] When society devalues the object of stigma, it can lead to exclusion and lowered social status. While animus is personal, stigma is social. Because of the widespread negative stereotypes associated with smoking and obesity, people who use tobacco or are overweight face social stigma.[80] Thus, even if a person does not have animus toward smokers or overweight people, she might still choose not to associate with them because of their inferior social status.

Programs – both public and private – that differentiate on the basis of health status may condone animus and perpetuate stigma.[81] Returning to examples from Chapter 1, when Dr. Bragdon refused to fill Sidney Abbott's cavity, that decision could have well been based in animus or stigma, as people who have HIV have faced ridicule and social exclusion. Turning away HIV-positive patients could perpetuate negative beliefs about that group, mainly that they are risky or dangerous. Perpetuating stigma is especially unfortunate when the stereotypic belief is unfounded. In fact, there is no evidence that HIV can be spread through routine dental care.[82] Social stigma may not only be harmful, but also misinformed.

Policies might not even need to specifically target a particular group or behavior to be healthist. When Mayor Michael R. Bloomberg adopted the Big Gulp ban, the tax applied equally to everyone, making it deceptively facially neutral. But the people of New York knew all too well that the policy was designed to decrease the consumption of sugary drinks because of their health impacts, which include weight gain and diabetes. One objection to bans on unhealthy foods and drinks holds that the law should not punish people who can eat and drink in moderation just because some people lack willpower.[83] Of course this argument is based in inaccurate, disparaging stereotypes about health and weight. Policies like the Big Gulp ban also may lead to animus and perpetuate stigma. If New Yorkers resent having to buy two smaller mochas at Starbucks, rather than one "Trenta" (thirty-one-ounce drink), they may blame overweight people for the cost and inconvenience. Moreover, the law serves

[79] Bruce G. Link and Jo C. Phelan, *Conceptualizing Stigma*, 27 *Ann. Rev. Socio.* 363, 367–75 (2001).

[80] Jessica L. Roberts and Elizabeth Weeks Leonard, *Stigmatizing the Unhealthy*, 45 *J.L. Med. & Ethics* 484 (2017); *see also* Lindsay F. Wiley, *Shame, Blame, and the Emerging Law of Obesity Control*, 47 *U.C. Davis L. Rev.* 121, 123–28 (2013) (noting public health campaigns aimed at stigmatizing obesity and smoking).

[81] Roberts and Leonard, note 15, at 850–1.

[82] Oregon Department of Education, *HIV-AIDS Questions and Answers* (2017), www.ode.state.or.us/search/page/?=1107.

[83] Wiley, note 79, at 125–6.

an expressive function,[84] signaling that law-makers view a lack of self-control as the reason behind obesity.

Because stereotypes play such a crucial role in human cognition, people may act on their negative beliefs despite their best efforts not to.[85] Consider the ACA's tobacco surcharge. Purportedly, Congress wanted people to quit smoking in an effort to improve public health and reduce health-care costs. Yet, why target tobacco use and not any number of other unhealthy and potentially costly behaviors? Why not drinking alcohol? Eating red meat? Getting inadequate sleep? Failing to exercise? Not using sunscreen? Failing to get the flu shot? Considering how much of our behavior affects our health, the decision to target tobacco use and not other kinds of risky conduct might say more about the social disdain for smokers than the desire to promote health or lower costs.[86] One solution to this thorny dilemma is to ensure that laws and policies designed to facilitate health or curb spending are actually based in evidence and do not target one behavior – or class of people –without a sound empirical justification. Looking to verifiable evidence can help ensure that law- and policy-makers are not acting based on animus or stigma. The ACA includes provisions supporting evidence-based medicine, dubbed "comparative effectiveness research" (CER), at least with respect to medical interventions and treatments.[87] Similar evidence could be further developed with respect to various health-promotion laws and policies. Studying the relative effectiveness of various approaches would also further welfare, ensuring that resources are put to efficient use.

2.2.4. *Health Justice*

The last guiding principle is health justice. Health justice draws from welfarist, egalitarian, and libertarian concerns related to people's access to care and health outcomes. Lindsay Wiley has described health justice as "emphasiz[ing] the need for more probing inquiry into the effects of class, racial, and other forms of social and cultural bias on the design and

[84] Cass R. Sunstein, *On the Expressive Function of Law*, 144 *U. Penn. L. Rev.* 2021 (1996), http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=3526&context=penn_law_review.

[85] Roberts and Leonard, note 15, at 886–7.

[86] Ibid. at 887.

[87] *See* Riaz Ali, Morgan Hanger, and Tanisha Carino, *Comparative Effectiveness Research in the United States: A Catalyst for Innovation*, 4(2) *Am. Health & Drug Benefits* 68–72 (2011), www.ncbi.nlm.nih.gov/pmc/articles/PMC4106578/. *Also see* Richard S. Saver, *Health Care Reform's Wild Card: The Uncertain Effectiveness of Comparative Effectiveness Research*, 159 *U. Penn. L. Rev.* 2147 (2011), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1690684 (identifying limits to the ACA's approach to comparative effectiveness research).

implementation of measures to reduce health disparities."[88] Health justice builds on other social justice movements grounded in human rights, equal opportunity, and fair treatment. Wiley has outlined similar trends in environmental justice, reproductive justice, and food justice.[89] Food justice, for example, focuses on the "disproportionate burden of environmental barriers to healthy food experienced by low-income communities and communities of color."[90] Similarly, health justice recognizes that various factors beyond individual choice affect health, including institutional policies and practices (e.g., where to dump pollutants, build state-of-the-art medical centers, locate walking trails or bike paths, allow liquor or cigarette advertising) as well as social determinants of health. But health justice's unique insight is that those factors are the result of existing bias and privilege and, accordingly, that reforms must address those underlying causes.[91]

Health justice overlaps with other guiding principles that we have discussed, but it also presents a unique set of concerns, values, and directives. From a welfarist perspective, health disparities and a lack of health-care access can reduce both short- and long-term welfare. From a libertarian perspective, limiting people's choices related to their health undermines personal freedom. From an egalitarian perspective, practices that classify and disadvantage certain groups or individuals are potentially animus-driven or stigmatizing. Although related to health welfare, health liberty, and health equality, health justice is distinct. In particular, health justice addresses distributive concerns at a systemic, society-wide level, focusing on underlying institutional structures and biases that have led to the maldistribution of health-care resources and opportunities.[92]

For one illustration of health justice concerns, consider the highly criticized disability law case, *Alexander* v. *Choate*.[93] In *Choate*, a group of people with disabilities challenged Tennessee's decision to reduce the number of Medicaid-covered hospital days from twenty to fourteen. The plaintiffs alleged that the change would disproportionately harm people with disabilities, who as a group tend to need more hospital care. Unconvinced by these

[88] Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 *Marquette Benefits & Social Welfare L. Rev.* 203–53 (2017).

[89] Lindsay F. Wiley, *Health Law as Social Justice*, 24 *Cornell J.L. & Pub. Pol'y* 47(2014).

[90] *See* Cassidy R. Hayes and Elena T. Carbone, *Food Justice: What Is It? Where Has It Been? Where Is It Going?*, 5(4) *J. Nutritional Disorders & Therapy* 1–5 (2015), www.omicsonline.org/open-access/food-justice-what-is-it-where-has-it-been-where-is-it-going-2161-0509-1000179.php?aid=64783.

[91] Wiley, note 88, at 84–5.

[92] Wiley, note 88.

[93] *Alexander v. Choate*, 469 U.S. 287, 105 S. Ct. 712 (1985).

arguments, the US Supreme Court upheld the fourteen-day limit, finding that Tennessee did not *intend* to discriminate against people with disabilities when reducing the number of covered hospital days. Moreover, people with disabilities had access to the exact same benefit – fourteen hospital days – as people without disabilities. While the Rehabilitation Act requires giving people with disabilities meaningful access to the Medicaid program, it does not guarantee them "adequate health care." The *Choate* court explicitly noted that Tennessee had no legal obligation to favor people with disabilities in its distributive decisions.

The *Choate* case certainly sounds in the register of healthism: The Tennessee Medicaid policy affects individuals differently based on a health-related factor. Despite its veneer of health-neutrality – the limit applied with equal force to all Medicaid beneficiaries – the *Choate* decision could have a devastating impact based on health status. Many people with disabilities depend on Medicaid as their source of health insurance.[94] They may require more regular and more intensive medical treatment than nondisabled persons. Because health care in the United States is so expensive, people could forgo needed treatment when their insurance fails to cover it. Hence, Medicaid beneficiaries in Tennessee who require longer stays might end up attempting to manage serious medical conditions on an outpatient basis. Or, if they are admitted, patients may find the hospital pushing them out the door because of the billing department's reimbursement concerns. Or they may receive all of the care that is medically appropriate but then face staggering bills for the days not covered by Medicaid. Given that Medicaid is a means-tested health-care program, the chances of the hospital actually collecting the additional charges are quite low. Nevertheless, the hassles of attempted debt collection and bad-debt write-off will add to the cost of doing business with Medicaid. Institutional and individual care providers, accordingly, may be even more reluctant to treat Medicaid patients because of the myriad challenges in getting paid for the care. (Medicaid already reimburses lower than Medicare and commercial insurance, creating a baseline disincentive to treat those patients.) In short, the change to the program would affect people with disabilities more acutely than nondisabled Medicaid beneficiaries. The reduction could limit their access to needed health care and, as a result, lower their relative health, thereby increasing existing health disparities.

Yet what principle of healthism does *Choate* violate? The decision is not clearly welfare-reducing. It could be that the overall benefit of reallocating

[94] *See* David S. Mandell and Colleen L. Barry, *Care for Autism and Other Disabilities – A Future in Jeopardy*, 376 *New Engl. J. Med.* e15 (2017) (describing Medicaid as "the single largest health-care payer for people with autism or developmental disabilities").

limited state funds away from Medicaid (or away from inpatient Medicaid coverage to other Medicaid benefits) outweighed any added burden that people with disabilities felt from fewer hospital days. The policy does not offend health equality because it does not single out people with disabilities based on animus or stereotype. Nor does it clearly violate health liberty. The policy limits, but does not deny, Medicaid beneficiaries' ability to stay in the hospital beyond fourteen days. The Court was careful to point out that people with disabilities have access to exactly the same set of choices as people without disabilities. Moreover, nothing actually forbids people from staying a fifteenth day in the hospital, assuming that they are willing to accept the charges. We might dispute just how voluntary that choice is, but theoretically both healthy and unhealthy individuals enrolled in Medicaid have the same option. Since the decision does not clearly violate health welfare, health liberty, or health equality, we must look to another governing principle to understand why *Choate* may be construed as healthist. Health justice provides such an explanation.

A law or policy transgresses health justice when it impedes health-care access, worsens health outcomes, or creates or perpetuates health disparities. Moreover, health justice acknowledges the underlying biases that influence institutional design choices. Although explicit bias like animus and stereotyping falls more properly under health equality, bias can also have collateral and structural effects. Recall that our definition of health equality does not readily include disparate impact. Instead we focused on individual decision-makers. To be sure, Tennessee cut its Medicaid inpatient hospital benefit not because of – but rather in spite of – its potentially devastating impact on people with disabilities. But why wasn't the state more attuned to the needs of disabled citizenry? Health justice recognizes that biases – including implicit ones – can get baked into a given system in such a way that makes them hard to identify as instances of discrimination. Perhaps ironically, the *Choate* court itself noted that "[d]iscrimination against the handicapped was . . . most often the product, not of invidious animus, but rather of thoughtlessness and indifference – of benign neglect." Yet when the state of Tennessee made Medicaid cuts that would have a disproportionately devastating impact on Tennesseans with disabilities, the state was arguably acting with a bias in favor of the needs of its nondisabled citizens while neglecting people with disabilities.

The effects of this example of benign neglect have clear implications for health justice. The decision in *Choate* impedes health-care access for people with disabilities, who tend to require more covered hospital days. Limiting access to needed care could lead to worse health outcomes. As a group, people with disabilities experience lower levels of relative health and poorer health

outcomes than people without disabilities.[95] Taking away six potentially medically necessary hospital days threatens to exacerbate those existing health disparities. In other words, the marginal utility of those additional inpatient days is greater for someone with a disability than for someone whose health status does not rely so heavily on the availability of that type of care.

Health justice then captures important concerns left untouched by the other three guiding principles, particularly the norm of distributive fairness. Because health is so tied up in other important social values, health law and policy should ensure that all Americans can access decent health care and can achieve baseline levels of health. Justice requires allocating society's benefits and burdens fairly across citizens.

John Rawls's concepts of the original position and the veil of ignorance provide a well-known account of justice. The original position is a hypothetical state of affairs in which a group of people convene to structure their society .[96] Behind the veil of ignorance, the framers do not know their race, sex, age, religion, intelligence, skills, level of education, or wealth. Because no one knows where they would stand in a social hierarchy, these hypothetical citizens adopt principles of justice that secure not only basic liberties but also the fair distribution of social resources, thereby creating a moral, just society. For example, imagine that you and I are charged with cutting a delicious cake. If one of us gets to cut the cake and the other gets to choose the first slice, then each of us should get our fair share.[97] Instead of cutting a variety of slices of different sizes and hoping we each get a bigger piece, we would instead cut all of the slices evenly. That result is what Rawls would call perfect procedural justice. In Rawls's hypothetical world everyone starts with certain basic liberties. In reality, of course, all people do not have access to the same set of choices.

Importantly, health justice, as we define it, is distinct from health equality. As a result, formal equal treatment can lead to unjust outcomes. Take the Aesop's fable of the stork and the fox.[98] When the crafty fox invites the stork over for dinner, the fox serves the stork milk (or, according to some versions of the fable, soup) in a shallow bowl. The fox can effortlessly lap up his meal from this container, while the stork – with his long beak – cannot. The stork

[95] Roberts and Leonard, note 15, at 897 (noting that people with disabilities are more likely to use nicotine or be overweight).

[96] Samuel Freeman, *Original Position*, in *The Stanford Encyclopedia of Philosophy* (2016), https://plato.stanford.edu/entries/original-position/#toc.

[97] John Rawls, *A Theory of Justice* (Harvard University Press, 1973).

[98] The US Supreme Court famously relied on this fable in *Griggs* v. *Duke Power Co.*, 401 U.S. 424 (1971), to explain why the law must reach even facially neutral, unintentional forms of exclusion to provide true equality of opportunity.

responds in kind by inviting the fox over for dinner and serving the liquid meal in a long, tall vessel. This time the stork's beak allows him to eat from the narrow jar with ease, and it is the fox that goes home with an empty stomach. Although both the stork and the fox may have been given equal quantities of milk, it would be a stretch to say that a world filled only with shallow bowls or narrow jars would be just for storks or for foxes, respectively.

So what does this discussion mean for our healthism project? Our version of distributive justice requires more than simply equal slices of cake or equal servings of milk. It likewise requires that people will be able to reach the table or will have access to utensils. And of course some citizens will come to the table hungry, while others already have had plenty of cake at home. Of course, applying the notion of distributive justice to real-world examples, such as health care, is a good deal more complicated.

Health justice recognizes that certain policies or laws may disproportionately harm particularly vulnerable groups,[99] including people labeled as unhealthy. For example, certain populations may be more likely to use tobacco or to be overweight. Specifically, people of certain races and ethnicities, people with disabilities, and those with lower incomes are more likely to smoke and to be heavier than their white, able-bodied, more affluent counterparts.[100] Laws and policies that penalize tobacco use and high BMIs, accordingly, will disparately impact these groups. Moreover, those populations already tend to experience lower levels of relative health.[101] Denying them certain privileges, such as reduced premiums or employer-subsidized wellness programs, exacerbates existing disparities and reinforces existing social stratifications.

Efforts to discourage or to punish unhealthy behavior may just pile onto these existing disadvantages. Recall the single parent living in poverty. She already faces significant obstacles to adopting healthy behaviors. Charging her more for health insurance because she does not hit her targeted BMI could simply add insult to injury. It is money diverted away from being able to buy healthier foods (which tend to be more expensive), obtain childcare (so she can exercise, sleep, or de-stress), or even pay for needed health care. Instead of improving her health and wellness, the policy could end up making her worse off. Thus, even well-intentioned differentiations based on health can exacerbate existing health disparities and make the lives of particularly vulnerable people even more challenging. As such, those policies raise distributive justice concerns even if they generate net welfare

[99] Roberts, note 43, at 607; *see also* Roberts and Leonard, note 15, at 905.

[100] Roberts, note 43, at 616–17.

[101] Ibid. at 617–18.

by improving some people's lives or by saving the employer or the health insurer money. In other words, a policy may serve health welfare yet still undermine health justice.

Imagine an employer decides not to hire women of reproductive age. The policy may be, from the employer's perspective, welfare-enhancing. Women of childbearing age, unlike their male counterparts, bear the physical and financial burdens of pregnancy and childbirth. Even if the child is adopted or born by a surrogate, in a heterosexual couple, the woman is more likely to be the primary caregiver for a newborn.[102] A pregnant employee may be costlier than a nonpregnant employee in terms of health insurance and productivity. Arguably, then, it would be economically rational for an employer to adopt a blanket policy against hiring women of childbearing age, say, under fifty. Even if a prospective female employee of that age has no interest in becoming a parent, a blanket policy is cheaper and easier to administer than trying to make individualized determinations regarding which applicants or employees might end up having children. Assuming a steady supply of capable workers that are men or women over fifty, an employer might decide the cost of the ban is worth the benefit.

However, the law restricts an employer's ability to adopt such a policy. Specifically, federal employment discrimination law prohibits discrimination based on age, pregnancy, and family leave.[103] Likewise, the ACA largely prohibits health insurers from making decisions about whom to insure and how much to charge in premiums based on individual health status. With respect to health status in other contexts, however, legal protections remain incomplete. For example, employers generally may refuse to hire tobacco users, obese workers, or other individuals deemed unhealthy or risky. Moreover, although the ACA's Essential Health Benefits (EHB) package includes preconception and prenatal care as "preventive services," the EHB requirement does not apply to employers, and preventive services do not include labor and delivery costs.

While the law would prohibit employers from screening out women of reproductive age, employers can still legally obtain information about their employees' reproductive choices. Companies like Castlight Health have created services to help employers mine their employees' health data, including workers' compensation claims, pharmaceutical records, doctor's appointments,

[102] Josh Levs, *"Primary" Caregiver Benefits Sound Gender-Neutral but Aren't*, *Atlantic*, Oct. 1, 2015, www.theatlantic.com/business/archive/2015/10/primary-caregiver-equality/404266/.

[103] *See* Age Discrimination in Employment Act of 1967, Pub. L. No. 90-202, 81 Stat. 602. (prohibiting discrimination against individuals 40 and over); Family and Medical Leave Act of 1993, Pub. L. No. 103-3, 107 Stat. 6; Pregnancy Discrimination Act, Pub. L. No. 95-555, 92 Stat. 2076.

and search queries on the companies' website.[104] Ostensibly, these companies aim to reduce employers' health-care costs by providing employees with information to make informed choices about their health and wellness. But the data miners can also predict whether employees are trying to get pregnant, are in need of major surgery, or are at risk for diabetes or other health conditions. For example, if an employee stops filling her prescription for birth control pills and searches the health plan website for covered obstetricians, she may be flagged as trying to get pregnant. So long as the data are not identified with a particular employee, the company could share it with the employer and stay clear of the Health Insurance Portability and Accountability Act (HIPAA). Nevertheless, that information may influence hiring decisions, either explicitly or implicitly.

Health justice also does work where health liberty might fail. As noted, people are not equally situated to make autonomous decisions. We can again go back to the single parent with limited resources. Offering an incentive to lose weight does not limit her choices or intrude on her privacy and, thus, does not offend health liberty. But the deck may be disproportionately stacked against her in terms of her ability to respond to the wellness incentive because of various socioeconomic, environmental, and other barriers to healthy eating and exercising. Therefore, it is entirely possible that a seemingly innocuous workplace wellness program might violate the principle of health justice by neglecting people who already face disadvantage.

While health equality certainly addresses some justice-oriented concerns, it would also leave some potentially healthist conduct unregulated. When animus or stereotype is driving discrimination, treating people equally is frequently enough to solve the problem.[105] For instance, if an employer does not want to hire women of reproductive age, eliminating discrimination is as easy as forbidding the employer from considering gender or age. It is enough to force the employer to treat men and women, and people of all ages, the *same*. In some cases, however, formal equal treatment can actually create or perpetuate disparities. Disability offers a helpful example. Frequently, treating people with disabilities the same as their nondisabled counterparts results not in

[104] Rachel Emma Silverman, *Bosses Tap Outside Firms to Predict Which Workers Might Get Sick*, *Wall Street Journal*, Feb. 17, 2016, www.wsj.com/articles/bosses-harness-big-data-to-predict-which-workers-might-get-sick-1455664940; Valentina Zarya, *Employers Are Quietly Using Big Data to Track Employee Pregnancies*, *Fortune*, Feb. 17, 2016, http://fortune.com/2016/02/17/castlight-pregnancy-data/.

[105] Susan Sturm, *Equality and Inequality: Legal Aspects*, *in International Encyclopedia of Social and Behavioral Sciences* 894 – 902 (James D. Wright, ed., 2nd edn., Elsevier 2015).

their inclusion but their exclusion.[106] To keep out people who use wheelchairs, an employer need not adopt a hiring ban. It can simply operate in a building with no ramps or elevators. Targeting discrimination may then require taking positive actions to make both facilities more accessible. We can think of our single parent in terms of access as well. She may have difficulty losing weight because her income and work hours limit her access to healthy foods or the time and other resources necessary to exercise. Health justice might call for accommodating her by providing healthy snack options at work or allowing exercise while on the clock.

In sum, a principle of health justice is necessary to understand healthism because it encompasses distributive justice concerns not captured by health welfare, health liberty, or health equality.

2.3. IDENTIFYING HEALTHISM

From these four guiding principles, we can create two sets of factors for law- and policy-makers, as well as private actors, to consider in evaluating the potential for healthism. The top section of Table 2.1 outlines the defining characteristics of desirable health-status differentiations, and the bottom section outlines the defining characteristics of healthism.

Identifying healthism requires a theoretically sound rubric. Not all health-based classifications are troubling. In fact, some can do a lot of good. Yet it is about more than just intent. Even well-intentioned classifications can have undesirable results, such as punishing people for things outside of their control, perpetuating stigma, exacerbating health disparities, invading privacy, or infringing on personal liberty. We therefore adopt four principles to guide our analysis of whether a law or policy is healthist: health welfare, health liberty, health equality, and health justice. From these four principles, we can formulate a framework to allow law- and policy-makers to think through these potentially thorny problems.

We apply this rubric in Chapter 6 by working though specific examples. This nuanced approach is necessary because health impacts people in so many different ways and raises so many competing concerns. Moreover, social norms, health-policy priorities, and empirical data change and develop over time. Our overarching goal is not to provide cookie-cutter answers to questions of healthism, but rather to heighten awareness of the pervasiveness of

[106] Jessica L. Roberts, *Health Law as Disability Rights Law*, 97 *Minn. L. R.* 1963, 2014 (2013).

TABLE 2.1. *Healthism Rubric*

Characteristics of socially desirable health-status differentiation
Promotes healthy decision-making*
Facilitates individual choices regarding health#
Lowers health risks*
Lowers health-care costs*
Facilitates better health care and better health-care access°
Characteristics of healthism
Is driven by animus†
Stigmatizes individuals unfairly†
Punishes people for their private conduct#
Impedes access to health care°
Cuts off resources or otherwise limits the ability to adopt healthy life choices#
Produces worse health outcomes°
Maintains or increases existing health disparities†

*Health welfare
#Health liberty
†Health equality
°Health justice

health-status discrimination and the need for closer attention to both its causes and its effects (Table 2.1). Our rubric is not an algorithm to apply mechanically. Instead, we seek to create a vocabulary and a platform for discussion to enrich the debates surrounding health policy.