THE RIGHT TO HEALTH PROTECTION

Tom H. Christoffel*

The state claims to be a state of property rights. Its purpose is to protect the people's property. Most people, however, possess nothing but their labor power, which depends entirely on their health. That is their only property and the state, therefore, has the duty to protect it and the people have the right to insist that their health, their only possession, be protected by the state.

*S. Neumann***

I. INTRODUCTION

Garfield Park is a black ghetto on the west side of Chicago, poor and badly serviced by the city. It recent years the Northwestern University Center for Urban Affairs studied the area's health problems, focusing on causes of hospitalization. The investigators discovered that the leading cause of hospital visits was automobile accidents. Another major cause was dog bites. The area recorded ten times the number of dog bites averaged in the rest of the city. Working with a local group called the Christian Action Ministry, the Center was able to induce the city to improve street maintenance and to cooperate in a roundup of wild dogs. This episode would seem to be a model for attacking problems by attacking the causes.[1]

Over a hundred years ago Rudolf Virchow, physican and reformer, wrote that "[m]edicine is a social science, and politics is nothing else but medicine on a large scale."[2] That poor health is primarily the result of controllable factors is no longer subject to much debate.[3] That the route to improved health is, therefore, primarily political is beoming equally evident. Since health relates closely to all aspects of life, from carcinogenic food to rutted streets, efforts to assure good health and to provide effective medical care must be very broad in scope. Since health levels correlate closely with income, and because income results from political-economic and not biological factors,[4] it is also clear that poor health results in large measure from factors under human cause and control.

---

* B.S., University of Wisconsin, 1964; J.D., Harvard Law School, 1967; Assistant Professor of Health Resources Management, University of Illinois School of Public Health.

** S. NEUMANN, DIE OFFENTLICHE GESUNDHEIT-SPFLEGE UND DAS EIGENTUM (1897), *as rendered in* H. SIGERIST, MEDICINE AND HUMAN WELFARE 95 (1941).

1. The program has received favorable comment. *See* 238 J.A.M.A. 1908 (1977); The Reader, Sept. 9, 1977, at 1.

2. 1 DIE MEDIZINISCHE REFORM 2 (1848), *as quoted in* H. SIGERIST, MEDICINE AND HUMAN WELFARE 93 (1970) [hereinafter cited as SIGERIST].

3. *See generally* AMERICAN COLLEGE OF PREVENTIVE MEDICINE, PREVENTIVE MEDICINE USA (1976) [hereinafter cited as PREVENTIVE MEDICINE].

4. On the continuing unscientific efforts to blame genetic factors for health and other problems, see A. CHASE, THE LEGACY OF MALTHUS (1976).

Thus, the concept of a right to health must incorporate the many factors affecting human health that are under human control. Moreover, while the right to medical care is important, especially in critical situations, it is only part of the concept. Thus, the right to be treated for dog bite does nothing to stop the danger from stray dogs. Attempts to assert a right to health must begin to focus on the broader issue of health protection as part of that right. This Article introduces the right to health protection in a preliminary way, in the hope that more detailed exploration of legal strategies and mechanisms will follow.

Of course many factors that influence health levels are already addressed by the law.[5] For example, Chicago probably could not legally defend shortchanging black ghetto areas in basic city services provided to other parts of the city.[6] But it was not the courts that helped pave streets and catch loose-running dogs in Garfield Park. Rather, it was self-organization combined with the "clout" of a major university, a component of which happened to interest itself in one poor neighborhood. Clearly, therefore, successful health measures depend on more than legal rights.

II. Health and Health Status

A standard dictionary definition of health is "the condition of being sound in body, mind, or spirit; *esp.* freedom from physical disease or pain."[7] *Black's Law Dictionary* includes a definition of health as the "[s]tate of being hale, sound, or whole in body, mind or soul; well being."[8] Although often criticized as too idealistic, the most cited definition of health is that of the World Health Organization, which calls it "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[9] Health is influenced by such varied factors as nutrition, standard and style of living, occupational satisfactions and hazards, natural and man-made environments, cultural perceptions, and the system of health-care services and delivery. Surprising though it may seem, the health care delivery system, which is the major focus of most right-to-health discussions, has relatively little impact on health status levels.[10]

Although health is usually defined in general and idealistic terms, levels of health or the state of being healthy are subject to measurement and com-

5. *See generally*, F. Grad, Public Health Law Manual (1976); K. Wing, The Law and The Public's Health (1976).

6. *Cf.* Hawkins v. Town of Shaw, 437 F.2d 1289 (5th Cir. 1971), *aff'd on rehearing*, 461 F.2d 1171 (5th Cir. 1972), *cert. denied*, 426 U.S. 245 (1975). *See generally* Lineberry, *Mandating Urban Equality: The Distribution of Municipal Public Services*, 53 Tex. L. Rev. 26 (1974); Clearinghouse for Civil Rights Research, The Wrong Side of the Tracks: Measuring Inequities in Municipal Services, Summer, 1975.

7. Webster's New Collegiate Dictionary 528 (8th ed. 1975).

8. Black's Law Dictionary 852 (Rev. 4th ed. 1968).

9. World Health Organization, Basic Documents 1 (25th ed. 1976). For a criticism of such an utopian ideal, see R. Dubos, Man, Medicine and Environment 67 (1968)[hereinafter cited as Dubos].

10. *See generally*, T. McKeown, Medicine in Modern Society (1966); McKeown, *A Historical Appraisal of the Medical Task*, in Medical History and Medical Care (1971); T. McKeown, The Role of Medicine: Dream, Mirage or Nemisis? (1976). Several critiques of the latter work are printed in Health and Society, Summer, 1977.

parison.[11] Such measurements include productive life span, age at death, specific causes of death, morbidity, reproductive efficiency, social dysfunction, self-perception of illness, and even the very fact of being under medical care. In terms of the most basic indicator—mortality—the level of health has improved greatly over the past two centuries.[12] The most important elements underlying this change have been improved water supplies and sewage systems, more abundant food, clean-food regulations, and other preventive measures[13] For example, in the United States, life expectancy at birth, which as recently as 1900 was 47.3 years, is now close to 72 years.[14] Almost all of this improvement results from lowered infant mortality rates, again due largely to improved sanitation and preventive measures. The exception was the period from 1936-1954 when the development of antibiotics was directly responsible for large-scale improvements in medical care. Since 1954, however, the death rate has remained relatively static,[15] and it has become increasingly evident that non-medical factors are likely to be the basis of further decline in that rate.[16]

This is not meant to disparage the role of medicine, but rather to emphasize the importance of environmental factors, including nutrition, in determining health status[17] and to underscore that any argument in behalf of a right to health must encompass more than medical care delivery. Before exploring this matter more directly, it is necessary to examine some pertinent

---

11. *See, e.g.*, R. BERG, HEALTH STATUS INDEXES (1973); R. KOHN & K. WHITE, HEALTH CARE: AN INTERNATIONAL STUDY (1976); D. SULLIVAN, CONCEPTUAL PROBLEMS IN DEVELOPING AN INDEX OF HEALTH (Public Health Service Pub. No. 1,000, 1966); Balinsky & Berger, *A Review of the Reserach on General Health Status Indexes*, 11 MEDICAL CARE 523 (1973); Fanshel & Bush, *A Health Status Index and Its Application to Health Services Outcomes*, 18 OPERATIONS RESEARCH 1021 (1970); Goldsmith, *The Status of Health Status Indicators*, 87 HEALTH SERVICE REPORTS 212 (1972).

12. Between 1750 and 1850 the death rate in England and Wales fell by an estimated 50%. With few effective medical treatments to account for the improvement, the most likely cause was an increase in food supply. Between 1850 and 1900 the death rate fell 14.6% thanks to decreased mortality from certain infections. *See*, J.G. FREYMAN, THE AMERICAN HEALTH CARE SYSTEM 11-15 (1974) [hereinafter cited as FREYMAN]. Presumably similar trends occurred in the United States, but U.S. vital statistics before World War I are too inadequate to be definitive.

13. McKeown and Lowe, conclude their historical review of health status as follows:

> We are now in a position to summarize our conclusions concerning the advance in health. It began in the eighteenth century and initially appears to have been due to changes in the environment, of which the most important feature was probably an improvement in the standard of living which resulted from the opportunities for employment offered by the Industrial Revolution. About a hundred years later this influence was supported by hygienic measures—control of water, sewage, housing, etc.—introduced progressively from the mid-nineteenth century and probably effective, particularly in prevention of bowel infections, from about 1880. The third major influence was the specific measure of preventing and treating disease in the individual, which, with the exception of vaccination, became available from 1925.

T. MCKEOWN & C. LOWE, AN INTRODUCTION TO SOCIAL MEDICINE 18 (1966).

14. U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH, UNITED STATES, 1975, 227 (1976) [hereinafter cited as HEALTH, UNITED STATES].

15. *See* FREYMAN, *supra* note 12. *See also*, PREVENTIVE MEDICINE, *supra* note 3, at 717-27.

16. *See* nn. 17-39 and accompanying text at pp. —, *infra*.

17. The contrast, however, is hard to avoid. As Dubos puts it:

> In this light, the extent of health improvement to be expected from building ultramodern hospitals with highly trained staffs and up-to-date equipment is probably trivial compared with results from the much lower cost of providing infants and children with well-balanced food, sanitary conditions, and a stimulating environment.

DUBOS, *supra* note 9, at 97.

statistics. While the 1970's offer the promise of longer and healthier lives than did the 1770's, there are important and revealing gaps.

The United States spends more on health care services than almost any other nation, both in absolute terms and in terms of health expenditures as a percent of GNP.[18] Yet, this country ranks seventh for females and nineteenth for males in life expectancy at birth.[19] Additionally infant mortality rates in the United States are almost twice that of Sweden.[20] Moreover, United States health and illness statistics continue to show a strong class of racial bias, with fewer preventive measures, poorer medical care, and more contributing causes of ill-health among those least able to afford the basics of life—a group that is disproportionately "non-White."

Significant differences appear when non-Whites are compared to Whites in terms of infant mortality,[21] birthweight,[22] Apgar scores,[23] immunization rates,[24] and total life expectancy.[25]

As of 1973, only 8.9% of Whites under 17 years old had never had a routine physical examination, compared to 14.8% of Blacks.[26] The difference according to income was even more dramatic: only 4.4% of all young people with family incomes over $15,000, but 20.3% for those with family incomes below $3,000 had never had a routine physical.[27] Similar differences occur in the percentage of women having Pap smears.[28]

Differences also exist in terms of physician visits. In contrast to the years immediately preceding the introduction of Medicare and Medicaid, the poor now average *more* physician visits per person per year than the non-poor.[29] But if use of services is measured relative to need for care, the

18. In fiscal 1974 the United States spent approximately $104.2 billion on health and medical care, almost $500 per person. This amounted to 7.7% of the total GNP. *See* NAT'L CENTER FOR HEALTH STATISTICS, HEALTH IN THE UNITED STATES, 1975, A CHARTBOOK 6 (1975) [hereinafter cited as HEALTH STATISTICS]. For comparative figures, *see* R. MAXWELL, HEALTH CARE: THE GROWING DILEMMA 18 (1974)[hereinafter cited as MAXWELL].

19. HEALTH, UNITED STATES, *supra* note 14, at 221 and 223 (with figures from 35 selected countries).

20. In 1969, there were 20.7 per 1,000 live births as compared to 11.7 for Sweden. MAXWELL, *supra* note 18, at 8.

21. Infant mortality rates for Blacks are almost double that for Whites: 37.6 compared to 19.5 per 1,000 live births for the period 1964-1966. HEALTH, UNITED STATES, *supra* note 14, at 353.

22. In 1972, 6.3% of the babies born to white women were of low-birth-weight, for non-white mothers the figure was 12.7%. HEALTH, UNITED STATES, *supra* note 14, at 371.

23. The Apgar score is a standardized numerical expression of the condition of a newborn infant. For the differences by race and income, see HEALTH, UNITED STATES, *supra* note 14, at 373.

24. Immunization rates for children, which are dangerously low for the entire population, vary dramatically by race. In 1974, the rate for polio among white children was 67%; among all other children, it was 45%. For rubella, the ratio was 61% as against 54%; for diphtheria-typhoid-pertusis, it was 76.8% as against 59.6%. *Id.* at 281. *See also*, HEALTH STATISTICS, *supra* note 18, at 52.

25. As reported for 1969-71, life expectancy was 71.62 years for Whites and 64.95 for all others. HEALTH, UNITED STATES, *supra* note 14, at 225.

26. A. MOSS, USE OF SELECTED MEDICAL PROCEDURES ASSOCIATED WITH PREVENTIVE CARE, UNITED STATES, 1973, 27 (Dep't HEW Pub. No. HRA 77-1538, March 1977).

27. *Id*, at 27.

28. Among White females over 14, 20.5 percent had never had a Pap smear; among non-whites it was 24.8 percent. Among women with incomes over $15,000 the figure was 14.9 percent; among those with incomes under $3,000 it was 39.0 percent. *Id*, at 20.

29. The poor averaged 4.3 physician visits in 1964, 5.6 visits in 1973. This compares with

poor have not reached a position of equity.[30] Moreover, despite the changes brought by Medicare and Medicaid, poor people are still less likely than the rest of the population to have visited a physician over a two-year period.[31]

The most striking difference is the much higher reliance on the hospital as a source of physician care by non-Whites.[32] The widely held view that hospital out-patient care is inferior to private office care is probably not true. The team-colleague system used in many teaching hospitals often provides better treatment than that provided by solo practitioners, many of whom do not keep pace with advances in medical knowledge and technique. But hospital-based treatment usually lacks one important attribute—continuity of care, thus patients who have the choice certainly prefer the ongoing relationship with one doctor.[33]

The most important indicators of health difference among various subgroups in the population are trends over time. Here the figures are far from encouraging. Socio-economic differentials in mortality and life expectancy, which had been narrowing in the decades prior to 1960,[34] are again increasing, even though the gap in utilization of health services between the poor and non-poor has narrowed.[35] This seeming paradox underscores the fact that increasing access to medical care does not always assure health.[36]

Especially revealing are self assessment health status interviews with persons ages 17-44 years old. Of individuals with incomes under $5,000 in 1973, 40.3% considered their health to be excellent; 61.5% of those with incomes over $15,000 made such a self-assessment. The figure for Whites was 54.2%; for all others, 38.0%.[37]

These variations among sub-groups of the population have been well

figures of 4.6 and 4.9 for the non-poor. For this purpose, "poor" refers to family income under $3,000 in 1964 and below $6,000 in 1973. HEALTH, UNITED STATES, *supra* note 14, at 289.

30. *See* Adrey, *Economic and Noneconomic Barriers to the Use of Needed Medical Services*, 13 MEDICAL CARE 447-457 (1975). *See also*, U.S. DEP'T OF HEALTH, EDUCATION, AND WELFARE, HEALTH OF THE DISADVANTAGED: A CHARTBOOK 34-48 (1977) [hereinafter cited as HEALTH OF THE DISADVANTAGED].

31. *See* HEALTH, UNITED STATES, *supra* note 14, at 289.

32. The following chart of 1973 physician visits by place for persons of all ages is based on date contained in HEALTH, UNITED STATES, *supra* note 14, at 293:

	Office	Hospital out-patient clinic	Hospital ER	Telephone	Home
White	70.2%	5.6%	3.5%	13.6%	1.5%
All other	60.1%	16.4%	7.0%	5.9%	0.4%

33. The significantly higher utilization of telephone consultation by white patients would also seem to suggest a superior continuity of care. *See* note 32, *supra*.

34. That narrowing gap is somewhat deceptive. A classic analysis by Fein demonstrated that, while black health status had been improving and the black-white health differential narrowing for many decades, black health status was improving at a slower rate than had been the case with Whites. In other words, it took Blacks longer to get from health indicator level A to level B than it had taken Whites to go from A to B years earlier. *See* Fein, *An Economic and Social Profile of the Negro American*, 94 DAEDALUS 815 (1965).

35. *See* Elinson, *Discussion of Papers Presented at the Session, Have We Narrowed the Gaps in Health Status Between the Poor and the Nonpoor?*, 15 MED. CARE 675 (1977); Lerner & Stutz, *Have We Narrowed the Gaps Between the Poor and the Nonpoor?*, 15 MED. CARE 620 (1977); Wilson & White, *Changes in Morbidity, Disability, and Utilization Differentials Between the Poor and the Nonpoor*, 15 MED. CARE 636 (1977).

36. *See* text at pp. —, *infra*.

37. HEALTH, UNITED STATES *supra* note 14, at 437.

documented,[38] and the reasons are fairly well understood. Most often they relate to those things of which poor people have less—good food, decent housing, jobs, and, in the area of medical care, preventive health-care services.

What do all these statistics mean? They indicate, first, that health status is the result of a wide variety of factors. Second, that many, if not most, of these factors are subject to human influence and control. Third, that because of the way human control over many of these factors has been exercised in the past, individual health status does not very randomly in the population, but is closely related to socio-economic factors. And finally, that improvement in health status is possible, and so is the elimination of these non-random differences.[39]

An adequate discussion of just how this improvement might be achieved is a broad and controversial subject that merits a great deal of attention. This Article, however, will limit itself to an examination of how law and the legal system can be used to foster improvement in health status, focusing first on the delivery of medical care services and then exploring other ways to protect human health.

III. EXISTING RIGHTS TO MEDICAL CARE

In recent years, a number of authors have discussed medical care as a

38. For most critical measures of disease, the poor compared to the non-poor and racial and ethnic minorities compared to Whites had higher incidences. Some examples of the differences:

	Racial Minorities/ White	Low/High Income
Mortality Over-all	1.42	1.60
Mortality due to cerebrovascular diseases	1.61	not available
Mortality due to tuberculosis	5.11	not available
Infant mortality	1.81	1.90
Maternal mortality	3.51	not available
Disability days (ratios are under-estimations)	1.17	3.18
Hypertension	1.66	not available
Tuberculosis	4.65	not available
Vitamin C deficiency	2.14	1.32
Calcium deficiency	1.43	1.21
Correctional institutional population	5.27	not available

Native Americans had incidence rates for several notifiable diseases, *e.g.*, chicken pox, mumps, hepatitis, tuberculosis, that were 3-13 times the rates for the rest of the U.S. HEALTH OF THE DISADVANTAGED, *supra* note 30, at 2.

39. Epidemics that used to be excused as acts of God are now not excused as the results of the inactivity of man. In short, the incidence of many diseases has been moved from the area of chance to the area of choice. That is a vast change intellectually. Not only intellectually but also morally, for such a series of accomplishments leaves us with a new system of ethics to devise, somewhat as the perfection of the automobile has called for new traffic law. As physicians we cannot evade a moral responsibility that goes with our newly acquired power. Having learned how disease come about, we find ourselves answerable for why it should occur at all.

Gregg, *The Golden Age of Medicine*, 30 ANNALS OF INTERNAL MEDICINE 810-822 (1949), *as quoted in* Karzon, *Immunization on Public Trial*, 297 NEW ENGLAND J. OF MED. 275-277 (1977).

legal right.[40] These discussions, often reflecting the authors' involvement in poverty and welfare law, have concentrated almost exclusively on entitlement to medical care services. The entitlement argument is usually based on statutory, contractual, or common law obligations to provide health care services to particular groups.

In some sense, a substantial majority of Americans already can be said to possess an enforceable right to medical care. Over 150 million people have work-related health insurance, including more than five million enrolled in prepaid comprehensive group practices. In addition, approximately 20 million people are covered by Medicare and another 25 million by Medicaid.[41] At the same time, about 41 million people have no health insurance at all.[42] And even those who do, especially those under Medicare and Medicaid, often find their coverage less than adequate.

Medicare,[43] which has apparently enabled the elderly to get more health care, nevertheless involves various exclusions, deductibles and co-insurance, as well as limitations on the number of days in hospitals that are covered.[44] Altogether, it is estimated that Medicare pays just over one-third of the health costs of the elderly.[45] Numerous cases have been tried directed at making Medicare operate more effectively, but such efforts are obviously limited by the Act.[46] Medicaid's restrictive eligibility requirements permit only fifty-nine percent of those who meet the Department of Health, Education, and Welfare definition of "poor" to receive coverage.[47] States participating in the program need only include the "categorically needy," such as recipients under Aid to Families with Dependent Children and Supplemental Security Income programs, and may limit the amount, duration, and

40. *See, e.g.*, CIBA FOUNDATION SYMPOSIUM, HUMAN RIGHTS IN HEALTH (1974); C. LEWIS, R. FEIN & D. MECHANIC, A RIGHT TO HEALTH: THE PROBLEM OF ACCESS TO PRIMARY MEDICAL CARE (1976); R. WHITE, RIGHT TO HEALTH: THE EVOLUTION OF AN IDEA (1971); Blackstone, *On Health Care as a Legal Right: An Exploration of Legal and Moral Grounds*, 10 GEORGIA L. REV. 341 (1976)[hereinafter cited as BLACKSTONE]; Cantor, *The Law and Poor People's Access to Health Care*, 35 LAW AND CONTEMP. PROB. 901 (1970)[hereinafter cited as Cantor]; Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U. L. REV. 492 (1974)[hereinafter cited as Carey]; Fried, *Rights and Health Care—Beyond Equity and Efficiency*, 293 NEW ENGLAND J. OF MED. 241 (1975); Sparer, *The Legal Right to Health Care: Public Policy and Equal Access*, 6 HASTING CENTER REP. 39-47 (1976)[hereinafter cited as Sparer].

41. Banta, *What Is Health Care?*, in S. JONAS, HEALTH CARE DELIVERY IN THE UNITED STATES 12, 22 (1976)(citing 1975 figures). The major health insurance role has long been held by the Blue Cross plans. A full understanding of current problems regarding medical care costs and resource allocation requires an appreciation of the Blue Cross role. *See generally*, S. LAW, BLUE CROSS: WHAT WENT WRONG? (1974).

42. Banta, *supra* note 41, at 22 (citing 1975 figures).

43. 42 U.S.C. § 1305 *et seq.* (1970). On the origins of Medicare, see T.R. MARMOR, THE POLITICS OF MEDICARE (1973).

44. *See generally*, Cypen, *Access to Health Care Services for the Poor: Existing Programs and Limitations*, 31 U. OF MIAMI L. REV. 127, 130 (1976) [hereinafter cited as Cypen].

45. Medicare's share of the total health bill for the elderly was 35% in 1974. In the last year before Medicare, direct medical costs paid by the patient were 10.3% of the income of persons aged 65 and older. After Medicare went into effect, this percentage dropped to 6.3% in 1968 and 1969, but it has been rising steadily ever since. By 1973, people over 65 were spending 8.1% of their income on direct medical payments. CAMBRIDGE RESEARCH INSTITUTE, TRENDS AFFECTING THE U.S. HEALTH CARE SYSTEM 117-127 (Dep't HEW Pub. No. HRA 76-14503, 1976).

46. *See* authorities collected in Butler, *An Advocate's Guide to the Medicare Program*, 8 CLEARINGHOUSE REV. 831 (1975).

47. 42 U.S.C. § 1396(f) *et seq.* (1970).

scope of Medicaid services.[48]

Health care providers, especially hospitals, have received considerable amounts of public monies, either directly through programs such as the federal Hill-Burton construction program[49] or indirectly under the federal tax exemption as charitable institutions,[50] and comparable state provisions. Only in the last decade, however, have efforts been made to enforce a *quid pro quo* of medical care without charge to the needy, and the results of these efforts have been quite limited. Despite language specifying that hospitals receiving Hill-Burton funds must provide "a reasonable volume of services to persons unable to pay,"[51] this obligation was effectively evaded for three decades.[52] Nor have lawsuits,[53] and a revamping of the program in 1974,[54] done much to change the situation. Certainly no individual can claim a specific entitlement to "Hill-Burton care,"[55] and the same is true with regard to tax exemptions afforded hospitals.[56]

Common law support for a right to medical care is also extremely limited. The only clear backing has come with respect to emergency situations. Some courts have held that if a hospital has an emergency room, true emergencies cannot be turned away, and that hospitals that do so risk liability.[57] Similarly, if treatment is undertaken by a hospital or physician, the patient cannot be abandoned, and the hospital or physician that does so risks liabil-

---

48. 42 U.S.C. § 1396a (a) (10) (c) (1970); 45 C.F.R. § 249 (10)(2)(5). *See generally* Cypen, *supra* note 44, at 130-33; Butler, *The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (1974).

49. 42 U.S.C. § 291 (1965). Between its enactment in 1947 and July 1, 1974, $4.1 billion was appropriated under the Hill-Burton program. *See* HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, NATIONAL HEALTH POLICY, PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974, H.R. Rep. No. 93-1382, 93d Cong., 2nd Sess. (1974).

50. 26 U.S.C. § 501 (c)(3).

51. 42 U.S.C. § 291 (e)(1) (1970).

52. *See* Comment, *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 HARV. CIV. RIGHTS CIV. LIB. L. REV. 351 (1973); Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975).

53. *See, e.g.*, Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La. 1970); Gordon v. Forsyth, 409 F. Supp. 708 (1976). The National Health Planning and Resources Development Act of 1974 explicitly authorizes a private right of action against hospitals participating in the Hill-Burton program by persons unable to pay for medical services. 42 U.S.C. § 300 p-2(c).

54. *See The National Health Planning and Resources Development Act of 1974*, 42 U.S.C. § 300K *et seq.* (1974); Schneider & Wing, *The National Health Planning and Resources Development Act of 1974: Implications for the Poor*, 9 CLEARINGHOUSE REV. 683 (1976).

55. *See generally*, Cypen, *supra* note 44, at 133-37; Rose, *supra* note 52; Sparer, *supra* note 40, at 40-41. *See also* Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La. 1970) for a discussion of the circumstances where plaintiffs may challenge either the absence of or the level of Hill-Burton services.

56. For a discussion of tax-exemptions for hospitals see Cypen, *supra* note 44, at 137-155; Sparer, *supra* note 40, at 41. *See also* Eastern Kentucky Welfare Rights Organization v. Schultz, 370 F. Supp. 325 (D.C., 1973) where the court held that designation of private non-profit hospitals as tax exempt charities by the Internal Revenue Service without requiring the hospitals to offer special financial consideration to persons unable to pay was an abrogation of Congressional intent. The Court of Appeals for the District of Columbia Circuit reversed, holding that the challenged revenue ruling was not contrary to Congressional intent, 506 F. 2d 1928 (1974). The Supreme Court vacated and remanded the Court of Appeals judgment and ordered dismissal of the case by the District Court on the grounds that plaintiffs had failed to establish their standing to sue. 426 U.S. 37 (1976).

57. *See, e.g.*, Wilmington Gen. Hosp. v. Manlove, 54 Del. 15, 174 A.2d 135 (1961); Guerrero v. Copper Queen Hosp., 22 Ariz. App. 611, 529 P.2d 1205 (1974). *See also* Cantor, *supra* note 40, at 909-13; Sparer, *supra* note 40, at 40.

ity.[58] But neither of these rules covers the right to medical care in the absence of an emergency, or after an emergency has passed.[59]

In recent years, a few states have enacted comprehensive health insurance statutes,[60] but the prospects for national health insurance service to assure a right to medical care for all citizens remain doubtful.[61] Since substantial governmental expenditures would be required, courts are likely to view the matter as strictly a legislative one. But an argument can be made for a constitutionally based right to medical care. After discussing the Supreme Court's disposition of two cases involving claims to medical care, the next section will review the constitutional arguments that might be advanced to secure health care as a legal right.[62]

IV. THE CONSTITUTION AND RIGHTS TO MEDICAL CARE

Under current Supreme Court precedent, medical care is not a constitutional right. However, the Equal Protection Clause could furnish the basis for an argument that unequal access to medical care based on income is a classifying standard which results in invidious, unconstitutional discrimination. Wealth, or rather, the lack of it, was not considered a special ground for equal protection until *Griffin v. Illinois*,[63] which required that all indigent defendants be furnished stenographic trial transcripts necessary for appellate review. Later the Supreme Court broadened its proscription of discrimination against the indigent by requiring appointment of counsel in appeals guaranteed by law.[64] The concept was further broadened in *Harper v. Virginia Board of Elections*,[65] which held that a poll tax was an invidious and

58. *See generally*, J. Waltz and F. Inbau, *Liability for Lack of Due Diligence and Abandonment of the Patient*, in MEDICAL JURISPRUDENCE 142-51 (1971).

59. Cantor argues in favor of a common law obligation of hospitals—at least governmental or voluntary ones—to offer services without excluding the indigent, although he admits that the proposal runs contrary to the mass of legal history. *See* Cantor, *supra* note 40, at 913-18. As regards the voluntary hospitals, establishment of such an obligation would first require that courts view hospitals as quasi-public, rather than as entirely private institutions. Such a quasi-public role was accepted in a case involving physician staff privileges. *See* Silver v. Castle Memorial Hospital, 53 Haw. 475, 497 P.2d 564 (1972), *cert. denied* 409 U.S. 1048 (1972).

60. *See, e.g.*, Connecticut Health Care Act of 1975, CONN. GEN. STAT. ANN. §§ 38-371 to 381 (1978); Hawaii Prepaid Health Care Act, HAW. REV. STAT. § 393 *et seq.* (1975 Supp.); Minnesota Comprehensive Health Insurance Act of 1976, as amended, MINN. STAT. §§ 62E.01-62E.17 (1976).

61. *See, e.g.*, *Chances for Health Insurance—Bleak in 77*, U.S. NEWS & WORLD REP., Feb. 14, 1977, at 35; Greenberg, *Health Insurance Stalled*, 81 SCI. DIG. 55 (1977); *Controversy in Congress Over National Health Insurance Proposals*, 56 CONG. DIG. 193 (1977). *See also Emerging Concepts of Federalism: Limitations on the Spending Power and National Health Planning*, 34 WASH. & LEE L. REV. 1133 (1977).

62. Health care accounts for over eight percent of the country's Gross National Product. The health care industry is the third largest in the nation in number of people employed. Yet health law has only recently begun to emerge as a distinct area of legal practice and study. Few courts seem to be knowledgeable in health matters, from basic epidemiology and public health (*See, e.g.*, Reyes v. Wyeth Laboratories, 498 F.2d 1264 (5th Cir.), *cert. denied*, 419 U.S. 1096 (1974), to the realities of medical care organization (*See, e.g.*, Eastern Kentucky Welfare Rights Organization v. Schultz, 506 F.2d 1278 (D.C. Cir. 1974).

63. 351 U.S. 12 (1956). Related cases are Eskridge v. Washington State Bd., 357 U.S. 214 (1958) (transcripts); Burns v. Ohio, 360 U.S. 252 (1959) (docket and filing fees); and Smith v. Bennett, 365 U.S. 708 (1961) (filing fees).

64. Douglas v. California, 372 U.S. 353 (1963). Justice Clark's dissent complained of a "new fetish for indigency." *Id.* at 358-59 (Clark, J., dissenting).

65. 383 U.S. 663-66 (1966).

impermissible discrimination by wealth. And in *Shapiro v. Thompson*[66] the Court found invidious discrimination in welfare residency restrictions. In each of these cases the Court was dealing with what it determined to be fundamental rights: in *Griffin*, a right of equal access to the criminal appellate process; in *Harper*, a right to vote; in *Shapiro*, the right to travel.

The most specific application of the Equal Protection Clause to the provision of medical care is found in *Memorial Hospital v. Maricopa County*,[67] but the case is limited to a specific statutory entitlement program. Under Arizona law, county governments have a mandatory duty of providing necessary non-emergency hospital and medical care for their indigent sick. In *Maricopa*, an indigent seeking free treatment at an Arizona county hospital was faced with the requirement of residency for one year to qualify for non-emergency medical care. Writing for the Court, Mr. Justice Marshall held that the durational residency requirement created an invidious classification which infringed upon the right of interstate travel established by *Shapiro*. Although the *Maricopa* case focused upon the right to travel, Justice Marshall did refer to medical care as a "basic necessity of life":

> Whatever the ultimate parameters of the *Shapiro* penalty analysis, it is at least clear that medical care is as much a basic necessity of life to an indigent as welfare assistance. And, governmental privileges or benefits necessary to basic sustenance have often been viewed as being of greater constitutional significance than less essential forms of governmental entitlements.[68]

Despite this language, *Maricopa* in no way obligates governments to provide non-emergency medical care to indigents or to others.

In light of the Court's decision in *Rodriquez v. San Antonio School District*,[69] holding that education is not a fundamental right, it seems unlikely at this point that medical care would be placed in that category. To do so would put government under an obligation to mitigate the effects of poverty and would have a major economic impact. If they were to establish a right to medical care, the courts would have to compel legislatures to enact and/or administrators to carry out a program for the equitable distribution of health resources—again an unlikely occurrence.[70] Most discussions con-

66. 394 U.S. 618 (1969).
67. 414 U.S. 250 (1974). *Noted in* 88 HARV. L. REV. 112; 60 A.B.A. J. 603 (1974).
68. 415 U.S. 250, 259 (1974).
69. 411 U.S. 1 (1972).
70. This has been done for mental patients confined by the state, but that is obviously a much narrower situation, since these patients are involuntarily confined and the confinement is justified—in principle—by a need for treatment. *See* Syatt v. Stickney, 344 F. Supp. 373 (M.D. Ala. 1972), 344 F. Supp. 387, 391 (M.D. Ala. 1972). Coons, Clune III, and Sugarman, *Educational Opportunity: A Workable Constitutional Text for State Financial Structures*, 57 CALIF. L. REV. 305 (1969), discusses the application of the discrimination by wealth principle to public education. *But see* San Antonio School Dist. v. Rodriquez, 411 U.S. 1 (1972). Estelle v. Gamble, 429 U.S. 97 (1976), *noted in* 68 J. CRIM. L. & CRIMINOLOGY 591 (1977), presents another situation. In *Estelle* the Court created a cause of action for prisoners where a "deliberate indifference" to the prisoner's serious illness or injury can be shown. The petitioner in that case was unable to demonstrate that he had been unconstitutionally denied medical attention, since he had been examined and treated on several occasions. The Court decided that his complaint of lack of diagnosis and inadequate treatment of a back injury raised issued of malpractice, rather than failure to provide care within the meaning of the standard outlined. 429 U.S. at 107. The case does not-take a small step in the direction of recognizing a right to medical care, however, even though it is limited to a class of

cerning a right to medical care therefore concede that the courts are not likely to establish such a right on board equal protection grounds.[71]

A somewhat different constitutional argument has been outlined by Michelman, who suggests that a more practical goal than equal protection is that of "minimum welfare."[72] In his view, the Supreme Court has employed just such a concept in *Griffin, Harper*, and *Shapiro*. As he explains:

> [T]he judicial 'equality' explosion of recent times has largely been ignited by reawakened sensitivity, not to equality, but to a quite different sort of value or claim which might better be called 'minimum welfare.' In the recent judicial handiwork which has been hailed (and reviled) as an 'egalitarian revolution,' a particularly striking and propitious note has been sounded through those acts whereby the Court has directly shielded poor persons from the most elemental consequence of poverty: lack of funds to exchange for needed goods, services, or privileges of access . . .[73]

Michelman points out that under the Equal Protection Clause, generally some sort of "inequality" must be present but that for the poor, "the injury consists more essentially of deprivation than of discrimination . . . ."[74] As a consequence, under Michelman's approach, "the cure . . . lies more in provision than in equalization, and that the reality of injury and need for cure are to be determined largely without reference to whether the complainant's predicament is somehow visibly related to past or current governmental activity."[75]

Michelman's argument is perhaps more appropriate to due process than to equal protection, but in either case it describes a phenomenon or process rather than a legal theory and dramatizes the absence of a consistent theoretical framework in dealing with rights and discriminations. Nevertheless the argument is particularly suited to the provision of medical care services. One possibility would be to define minimum protection in terms of level of services. One writer observes that interventions can be "placed on a scale of increasing cost and complexity, in terms of both the equipment needed for them and the demands upon the operator who does them."[76] He goes on to suggest that "[p]erhaps there is a 'threshold' somewhere on these scales below which everything might be included as a human right."[77]

Government intervention in providing medical care, even at the minimal level, would be conducted most sensibly through a national health serv-

persons whose claims to treatment can be distinguished from that of the general population. In addition, *Estelle* was based on the Eighth Amendment, rather than on an implied right to medical treatment, or even to another explicit constitutional provision which could be applied outside the prison walls. Under the Eighth Amendment, as interpreted by the plurality in Gregg v. Georgia 428 U.S. 153 (1976), punishents which "involve the unnecessary and wanton infliction of pain" are unconstitutional. *Id.* at 172-73.

71. *See* Carey, *supra* note 40, at 503; Blackstone, *supra* note 40, at 396. Most discussions point particularly to Dandridge v. Williams, 397 U.S. 471 (1970) as revealing the Supreme Court's unwillingness to expand the fundamental rights category. *See*, Cantor, *supra* note 40, at 904.

72. Michelman, *The Supreme Court, 1968 Term—Forword: On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7 (1969).

73. *Id.* at 9.

74. *Id.* at 11.

75. *Id.* at 13.

76. King, *Personal Health Care: The Quest for a Human Right*, in HUMAN RIGHTS IN HEALTH, *supra* note 40, at 229-30.

77. *Id.*

ice. Lacking that, the courts must find some leverage in a private delivery system. Courts have been increasingly willing to find state action in the activities of medical care providers, most notably hospitals,[78] but to guarantee a right to medical care some violation of the Equal Protection Clause, or of a duty to protect against the health ravages of economic inequality, must be demonstrated. Should it ever choose to use the minimal protection approach, the Court would have a theoretical basis for rationalizing enforcement of a right to medical care.[79]

Both the federal and state governments are already heavily involved in health care through entitlement programs and direct payments to providers, government run hospitals and clinics, licensure of health care personnel and provider institutions, tax exemptions, health insurance regulation, and the like. These activities suggest that the most likely mechanisms for converting a minimal health protection principle into actual medical care for the disadvantaged would be expansion of this existing governmental health role. But advocates of a right to health lack a lever of proven constitutional effectiveness, and judicial intervention seems politically less likely than legislative action.

V. A RIGHT TO HEALTH PROTECTION?

Medical care focuses on *curing* disease as a means of improving health status. But effective improvement of the public's health depends even more on dealing with the cause of disease than it does on its cure.[80] This includes control of communicable diseases, regulation and improvement of the physical environment, and food and water sufficient in both quality and quantity.[81] More recently, these traditional concerns have broadened to include conditions of employment[82] and other factors involving *health protection*, which encompasses both preventive medicine (*e.g.*, immunization, screening and detection, accident prevention) and promotion of an environment con-

78. *See, e.g.*, Silver v. Castle Memorial Hosp., 53 Haw. 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972); Simkins v. Moses H. Cone Memorial Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964); Sussman v. Overlook Hosp. Association, 92 N.J. Super 163, 231 A.2d 389 (1967). Carey, *supra* note 40, at 495-501, discusses state action in the medical context.

79. There is a "flexibility" here that is characteristic of the way in which the Equal Protection Clause has generally been employed by the courts. *See* Blackstone, *supra* note 40, at 399. Michelman finds a mixed response to resting his argument on equal protection rather than due process grounds:

> [T]he due process clause inveighs only against certain 'deprivations' by the 'state', occurrences which seemingly cannot occur by more default. . . . [T]he Court seems currently more comfortable in staking out and valuing 'fundamental' interest under the aegis of equal protection than it could well feel under due process.

Michelman, *supra* note 71, at 13, 17.

80. *See* note 10, *supra*. It is important to emphasize that attention to the prevention of disease must not be at the expense of medical treatment. That type of conservative distortion has been popularized by Ivan Illich and others. *See* I. ILLICH, MEDICAL NEMISIS: THE EXPROPRIATION OF HEALTH (1976). *Cf.* Crawford, *You Are Dangerous to Your Health: The Ideology and Politics of Victim Blaming*, 7 INT'L J. OF HEALTH SERVICES 663 (1977).

81. *See* 39A C.J.S. §§ 18-47 (1976); G. ROSEN, A HISTORY OF PUBLIC HEALTH 428-90 (1958).

82. *See* Brenner, *Health Costs and Benefits of Economic Policy*, 7 INT'L J. OF HEALTH SERVICES 581 (1977); REPORT OF SPECIAL TASK FORCE TO SECRETARY OF HEW, WORK IN AMERICA (1973). *See also*, 42 U.S.C. § 1, *et. seq.* concerning the U.S. Public Health Service.

ducive to better health (*e.g.*, health education, environmental and occupational health measures, nutrition, risk-factor intervention).

The most rational government approach to the issue of a right to health is to concentrate on health protection, not only because this is the most direct and effective approach to the problem, but also because it fits most easily into the traditional role of government as a societal regulator rather than simply as a provider of funds. This concept is not new; governmental health policy carried out through administrative regulations—the "medical police"—was popular in Germany in the eighteenth century.[83]

In the United States, public health and safety measures have a long tradition.[84] No public policy is more important than the protection of the people from practices which may injure their health, and governments have traditionally exercised broad public health powers.[85] But faced today with more of a threat from contamination in the air than from that in the streets, public health measures seem to be meeting increasing resistance. This should not be surprising, for unlike controls aimed at communicable diseases and poor sanitation, environmental and occupational health measures impinge directly on private business interests. The property oriented legal system is well suited to defending property owners' "rights," even when these include poisoning and endangering the living and working environments. Thus, efforts to protect the public from health hazards cannot be expected to receive automatic judicial endorsement.[86] The key question is how to find the appropriate leverage with which to enforce health protection, and efforts toward this end have included common law, statutory and constitutional approaches.

Common law actions have played a limited role in protecting the public's health. Although the authority to abate public nuisances without compensation for property loss seems clearly available,[87] it is not often successfully used, especially by individual complainants.[88] Tort actions

---

83. *See* Rosen, *supra* note 80, at 161-67. The use of the word "police" in this context suggests an anology to crime control that holds a certain appeal. The poor, and especially the black poor, are the most frequent and most vulnerable victims of both crime and disease. In the United States, government has always provided protection from criminal acts, although it has only recently begun to fund victim compensation programs. *See, e.g.*, Brooks, *The Case for Creating Compensation Programs to Aid Victims of Violent Crimes*, 11 TULSA L. J. 477 (1976); Note, *Pending Crime Victim Compensation Legislation in Iowa: An Analysis*, 26 DRAKE L. REV. 838 (1977); MD. ANN. CODE Art. 26A §§ 1-17 (1973), as amended. As regards health, the situation is reversed, *i.e.*, various entitlement programs provide some compensation to the victims of disease, but protection from disease was until quite recently limited to sanitation and contagious disease control.

84. *Id.* For the modern period *see* G. ROSEN, PREVENTIVE MEDICINE IN THE UNITED STATES 1900-1975 (1975).

85. Friedlander v. Cimino, 385 F. Supp. 1357 (S.D.N.Y. 1974), *rev'd on other grounds and remanded*, 520 F.2d 318 (2d Cir. 1975).

86. New challenges are being developed, however. *See*, THE NATIONAL DEFENSE COUNCIL, LAND USE CONTROLS IN THE UNITED STATES: A HANDBOOK ON THE LEGAL RIGHTS OF CITIZENS (1976).

87. *See* Grad, *supra* note 5, at 122-33; Note, *Toward Recognition of Nonsmokers' Right in Illinois*, 5 LOY. (CHI.) U.L.J. 610, 618-22 1974; Note, *Constitutionalism and Ecology*, 48 N. DAKOTA L. REV. 37, 316 (1972).

88. In one sense, the citizen suit provision of the Clean Air Act simply provides for an enhanced version of public nuisance suits. *See* 42 U.S.C. § 1857h-2(a) (1970).

have not proved very successful as deterrent[89] or preventive measures, but they hold a strong theoretical potential value for health protection. The failure of product liability actions for smoking induced lung-cancer deaths would seem to be discouraging, but this may represent the most difficult extreme.[90] A recent $20 million settlement payment to asbestos workers suffering from lung cancer and asbestosis may herald similar actions. The parties agreeing to contribute to the settlement included not only the owners of an asbestos plant, but also government inspection agencies which had failed to inform the workers of the health hazard they faced.[91]

The success of common law actions in protecting health will depend on the availability of good scientific data to present to courts. This might be an easier task than developing new legal arguments which assert broader governmental health obligations. The task may also be eased to the extent that courts begin to accept risk-benefit balancing as part of their standard of proof in health related cases.[92]

Both state and federal legislatures have recently been forced to pay more attention to regulating the general environment, and particularly the workplace. State and federal occupational safety, health and environmental protection laws[93] would seem to have had their successes,[94] though they also tend to create programs that are understaffed, undersupported, and quite often timid. The result is an inability to successfully tackle some of the biggest health threats.[95]

Perhaps the greatest promise for effective health protection lies in efforts to increase enforcement of existing statutes. Ideas and statutes are not lacking as much as are the resources for using them to maximum effectiveness. If more attorneys get involved in health related litigation, and if data is more effectually compiled, it may be possible to push existing law to its fullest potential in much the same way that welfare and privacy law has been aggressively developed.

A constitutional claim to a decent environment, based on due process or Ninth Amendment grounds, has won little support in the courts,[96] since both

89. Malpractice actions have served as the chief medical care quality control mechanism. *See* C. JACOBS, MEASURING THE QUALITY OF PATIENT CARE 4 (1976).

90. *But see* Garner, *Cigarettes and Welfare Reform*, 26 EMORY L.J. 269, 295-307 (1977). *See also*, RESTATEMENT (SECOND) OF TORTS § 402, COMMENT b (1965).

91. *See Asbestos Workers Illness—and Their Suit—May Change Health Standards*, N.Y. Times, Dec. 20, 1977, at 30, col. 1; *Employee's Common Law Right to a Safe Workplace Compels Employer to Eliminate Unsafe Conditions*, 30 VAND. L. REV. 1074 (1977).

92. *See, e.g.*, Reserve Mining Co. v. Environmental Protection Agency, 514 F.2d 492, 537 (8th Cir. 1975), *noted in* MINN. L. REV. 893, 901 (1975).

93. *See, e.g.*, The Occupational Safety and Health Act of 1970, 29 U.S.C. § 651 *et seq.*; The National Environmental Policy Act of 1969, 42 U.S.C. § 4321 *et seq.*; The Clean Air Act of 1970, 42 U.S.C. § 1857 *et seq.*; The Illinois Environmental Protection Act, ILL. REV. STAT. Ch. 111 1/2 § 1001 *et seq.* (1975).

94. For one of the success stories, *see* Currie, *Enforcement Under the Illinois Pollution Law*, 70 NW. U. L. REV. 389 (1976).

95. *See, e.g.*, Kraus, *Environmental Carcinogenesis: Regulation on the Frontiers of Science*, 7 ENVT'L L. 83 (1976).

96. For a succinct discussion of this topic *see* Note, *Toward Recognition of Nonsmokers' Rights in Illinois*, 5 LOY.U. (CHI.) L.J. 610, 614-18 (1974). *See also* Howard, *State Constitutions and the Environment*, 58 VA. L. REV. 193 (1972); Curran, *A Constitutional Right to a Health Environment*, 67 AMER. J . OF PUBLIC HEALTH 262 (1977). In Pickney v. Ohio Environmental Protection Agency, 375 F. Supp. 305 (N.D. Ohio, 1974), the court ruled that:

the federal and most state constitutions are silent regarding environmental matters. The most meaningful exception is the new Illinois State Constitution, which provides:

> Each person has the right to a healthful environment. Each person may enforce this right against any party, governmental or private, through appropriate legal proceedings subject to reasonable limitation and regulation as the General Assembly may provide by law.[97]

This provision creates standing to sue to enforce an individual right to a healthful environment, without requiring special damages or state action. It is not yet clear what this may mean, but it might be used to create standing in common law public nuisance suits or to allow courts to more openly make environmental policy judgments.[98] Just how effective the constitutional provision will be in protecting health remains to be seen, but it is an invitation to push for effective health protection.[99]

VI. CONCLUSION

The term "right" has at least three different connotations: What the law is, what it is likely to be, and what it should be. In the foregoing discussion, the term has been used in a rather loose fashion, reflecting the writer's conviction that "rights" are whatever the courts and other political institutions choose to, or are forced to, make them at any particular time. President Carter gave some support to the right to health protection when he stated:

> One of the most basic of human rights is the right to good health care. In recent years we have come to understand that health care is not merely a technical problem for medical specialists. It is a vital concern for all who help shape the economic, social and political processes of our communities and nations.[100]

Notwithstanding this supportive presidential language, those concerned with translating a right to health into a meaningful reality face an uphill battle. The preceding pages have outlined the present situation and pointed to the important role the protection of health must play in that battle. The law can be a valuable tool in some aspects of the campaign. But as Henry Sigerist, a most perceptive student of history and health, observed, "[H]ealth cannot simply be dispensed to the people. They must themselves want it and must fight for it."[101]

> The task of defining a 'deprivation' as that term relates to the interest in a healthy environment is beyond the competence of the courts and is instead a task characteristically performed by the legislative branch. Therefore the court does not rule that an interest in a healthful environment, as alleged on the facts of this case, is an interest of such a nature that procedural due process attaches.

97. ILL. CONST. art. 11, § 2.

98. "Where . . . [Environmental Protection Agency] regulations turn on choices of policy, on an assessment of risks, or on predictions dealing with matters on the frontiers of scientifc knowledge, we will demand adequate reasons and explanations, but not 'findings' of the sort familiar from the world of adjudication." Amoco Oil Co. v. Environmental Protection Agency, 501 F.2d 722, 741 (D.C. Cir. 1974).

99. Although presumably within a narrow definition of environment (*i.e.*, not encompassing housing, employment, etc.).

100. Statement by President Jimmy Carter, Nov. 11, 1977, *as quoted in* 7 THE NATION'S HEALTH 9 (1977).

101. SIEGERIST, *supra* note 2, at 98.