

HEALTH CARE AS A COMMUNITY GOOD

Many Dimensions,
Many Communities,
Many Views of Justice

by CHARLENE A. GALARNEAU

We often speak of health care as a social good. What kind of good it is—and what justice requires of us in making it available to the members of society—depends on how society understands it. Yet the value of health care may be understood in many different ways within society.

Justice pivots partly on our understandings of goods. In the words of Michael Walzer, “all distributions are just or unjust relative to the social meanings of the goods at stake.”¹ So too with health care. Over a quarter century ago, Robert Veatch held that “any abstract argument about distribution principles in health care without pinning down precisely what is being distributed will be fruitless.”² Nearly a decade later, in the first book-length treatise on justice and health care, Norman Daniels noted the futility of applying general theories of justice to health care without knowing “what kind

of social good health care is.”³ Recent discussions of the commodification of health care—that is, of the changing nature of health care as a social good—highlight its implications for just health care.⁴

Yet despite this long-standing belief and despite the health care reform efforts of the last decade, relatively little critical ethical attention has been given to the wide-ranging social meanings of health care. What does it mean to say that health care is a *social* good? What persons or groups are implied by *social*? What roles do they play in health care? And in *just* health care?

The phrase “health care is a social good” is often used to mean health care as a societal or national good signifying that “society” or “nation” (often used interchangeably) is the pertinent social group for health care. But so-

Charlene A. Galarneau, “Health Care as a Community Good: Many Dimensions, Many Communities, Many Views of Justice,” *Hastings Center Report* 32, no. 5 (2002): 33-40.

ciety is not the only, nor even the primary, social collectivity relevant to health and health care. Both health and health care involve a much more complex and diverse set of social relations and contexts, including those at the interpersonal, family, community, state, regional, national, continental, and global levels. A full conceptualization of health care as a social good would recognize its multilayered reality and its many intercontextual connections.

Let us say, for now, that communities are various types of social collectivities typically smaller than a society and larger than a family. Geographically defined groups may be communities. So also may racial, ethnic, religious, cultural, and professional groups. Communities, I argue, are the primary contexts for the social relations and institutions most central to health and health care, and they are critical moral resources in any effort to make health care more just. But because communities are complex and overlapping entities, any effort to make health care more just will be more complicated than most commentators have recognized.

Communities Neglected

Bioethics has been appropriately criticized for its narrow emphases on autonomy, individualism, and the dyadic relations between physicians and patients, and researchers and subjects. Says Susan Wolf, "Bioethics has strained for universals, ignoring the significance of groups and the importance of context."⁵ To the extent that "community" and communities have been addressed in relation to just health care, three problems are evident: "community" has multiple, unexamined meanings; the overall importance of real communities is minimized; and specifically the moral and ethical significance of communities is neglected.

These difficulties are exemplified in the ethical framework offered by Dan Brock and Norman Daniels for reforming the U.S. health care sys-

tem. In this framework, fourteen ethical principles and values are claimed to "provide a tool for the broad moral assessment of a reformed health care system and its performance over time."⁶ These principles and values, including universal access, comprehensive benefits, and fair burdens, are asserted to be "deeply anchored in the moral traditions we share as a nation, reflecting our long-standing commitment to equality, justice, liberty, and community" (p. 1189).

The first problem is this framework's use of the word "community" to refer to multiple, morally and otherwise distinct social groups. "Community" most often refers to society or the nation, as is obvious in the phrase, "a *single national* community," and as is implied in, "To further bind us together as *one* community . . ." But "community" also means the "*many other* communities that flourish within our society: religious, racial, and ethnic, as well as the neighborhoods, towns, and cities in which people share a common life." The rhetorical affirmation of these smaller communities is strong: "We celebrate our diversity as a nation. Our many religious, ethnic, and cultural traditions and groups are among our greatest strengths; they show us the many ways we can lead a good life."

Ultimately, though, the contributions of these smaller communities are minimized in favor of a vision of a single harmonized national community—the second problem. Unifying phrases prevail: "*widely shared* ethical principles and values," "deeply anchored in the moral traditions we share *as a nation*," and "*widespread consensus* on their central role in defining *our common community*." The particularities of subnational communities are diminished: "different moral, religious, and cultural traditions within our society *may emphasize* different elements of these principles and values or weigh them differently when they conflict. *Nevertheless*, there is a widespread consensus . . ." And again, "these

differences will *sometimes* lead us to disagree . . . *Despite our diverse origins*, we share a broad consensus and commitment as a nation . . ."

Third, subnational communities play virtually no moral role in health care reform, despite the authors' assertion that "fundamental to these different communities is a shared concern and responsibility for one's fellow members, especially those suffering misfortune and in need of help." This fundamental community concern and responsibility is not linked to any of the fourteen ethical principles and values proposed to guide health care reform. In fact, of the four moral ideals, only community *fails* to do the moral work of grounding one or more of these fourteen principles and values. Equality grounds the principles of universal access, comprehensive benefits, equal benefits, and generational solidarity; justice supports the principles of equal benefits, fair burdens, generational solidarity, wise allocation, effective treatment, quality care, efficient management, and fair procedures; and liberty grounds individual choice, personal responsibility, and professional integrity. Community grounds none of these principles and values.⁸ With the erasure of the "shared concern and responsibility" of communities, community as a "deeply anchored" moral foundation becomes community rhetoric.

Finally, this framework for health care reform contains a third meaning of community: community as a "sense" of community born of a common health care system. Here the authors understand community to refer to both subnational and national collectivities: "a health care system that embodies the principles and values identified . . . strengthens the shared concern for others that already exists in the many communities that make up our nation. A common health care system that serves and cares for us all will also help bind us together in a broader national community."

This neglect of actual communities combined with hope for a future,

stronger sense of community is not uncommon in bioethical discussions about justice and health care. Dan Beauchamp's notion of republican equality "seeks to foster a more spacious and generous sense of [national] community, one in which common provision and common possession in the case of health protection, symbolizes a common membership in a republic of equals."⁹ Larry Churchill advises that "rather than assuming community as the foundational element in our arguments, we should look to a universal health care system to help develop a greater sense of [national] community."¹⁰ Churchill also understands that "we function largely in work-related, religious, residential, or recreational enclaves" (p. 57) and that these "sovereign groups" are "the shrunken We of special interests" and thus are a "serious enemy of universal care" (p. 72). These limited and sometimes dismal portrayals of community do not account for the complex, constructive involvements of actual communities in health and health care, not to mention in just health care.

Community Dimensions of Health and Health Care

Health care is a community good in at least four ways: (1) significant meaning-making related to health and health care takes place in communities, (2) human health is notably conditioned by communities, (3) health care involves myriad community-based relationships, and (4) communities accrue many of the social benefits of health care.

Community meaning-making. Health care is a social good in part because its meanings are socially created. Our understandings of health, illness, death, and health care are social constructions continually subject to revision and re-creation. These understandings are clarified and transformed in ongoing social processes of meaning-making.

While national "culture" broadly influences medical practice,¹¹ the

medical profession has been more influential in defining health and illness for both individuals and societies. By collective professional decision, particular "conditions" have been defined in or out of illness status, witness the medicalization of alcoholism and the demedicalization of homosexuality. While medical practice within a nation tends to exhibit similar characteristics, substantial practice variation exists by geographic area, reflecting the development of not only

□

Health care is a social good in part because its meanings are socially created. Our understandings of health, illness, death, and health care are social constructions, clarified and transformed in ongoing social processes.

□

regional but also rather localized norms of practice.¹²

Perhaps more importantly, we develop understandings of health and health care within particular cultural and religious communities that embrace fundamental ideas about life, death, health, and illness. The value differences between biomedicine and cultural and religious communities become starkly obvious in narratives such as Ann Fadiman's *The Spirit Catches You and You Fall Down*, the tragic story of a Hmong family's encounter with well-intentioned biomedicine.¹³ Christian Scientists have comprehensive faith-based understandings of health with corresponding healing practices that are significantly different from those of biomedicine,¹⁴ while other religious

communities embrace biomedicine but with restrictions, such as Jehovah's Witnesses' proscription of the use of blood and blood products.¹⁵

Such particularized understandings of health and health care are not restricted to relatively small communities. Many racial-ethnic groups embrace understandings of health and illness that blend traditional cultural beliefs and scientific thought.¹⁶ The official teachings of the Roman Catholic Church promote understandings of human life that prohibit certain health care practices related to sexuality and reproduction, including condom use, abortion, and sterilization.¹⁷

Important health-related meaning-making also occurs in less discretely identifiable communities, for example, among feminists, people with disabilities, and in the lesbian, gay, bisexual, and transgender communities. Motivated by medicine's neglect of their understanding of their health care needs, feminists have had some success in redefining common ideas about health and health care. The demedicalization of childbirth and menopause are two such changes brought about largely by the women's health movement.¹⁸ Through the disability rights movement, people with disabilities have developed, embraced, and spread new ways of thinking about disability. In particular, they have promoted the understanding that disability is socially created through a lack of access and accommodation, rather than being solely an individual and biomedical concern.¹⁹ More recently, lesbian, gay, bisexual, and transgender communities have been working to redefine common ideas about sexual identity and reduce the neglect of sexual minorities in research and health care services.²⁰

Clearly we do not create meanings of health and health care de novo. We are born into, join, and live in communities with particular health and healing traditions. Meaning-making is an ongoing and dynamic process, and community-based meanings are continually being reshaped by influ-

ences both internal and external to communities. Multiple meanings co-exist and interact as communities share members and otherwise associate with one another.

The community nature of health. In important measure, human health is the result of physical and social macro-environments at the local community level. The physical environment, including air, water and soil quality, urbanization, climate, noise levels, and housing and transportation patterns, affect human health.²¹ So, too, does the social environment. Recent studies show that certain social relationships, including family and friends, marriage, church membership, and other group affiliations are generally beneficial to health, though the benefits vary by sex, race, and income.²² Less socially integrated persons have a significantly greater risk of mortality and perhaps of morbidity.²³ To the extent that communities promote or inhibit these interpersonal relationships, communities play a significant role in health.

One person's ill health can affect the physiological and emotional health of others connected by proximity or social relation. Contagion is perhaps the most obvious example: infectious diseases such as influenza, tuberculosis, and HIV are spread among persons interacting in close contact with one another in homes, schools, day care centers, hospitals, shelters, and work sites. Thus contagion is typically a feature of local communities more than of societies or nations. Similarly, an ill person's suffering and need for care affect mainly the members of immediate and local communities.

The impact of a community's social environment, as evidenced by group disparities in health status and access to care, has become the subject of serious epidemiological study. Recent studies point to socioeconomic status, income inequality, social stress (including crowding, family instability and violence), and social cohesion as important health influences.²⁴ Structural pluralism, defined as "the

degree to which organizations and population segments of a community have the capacity to participate in political exchange," has been shown to be predictive of lower mortality.²⁵

Community-based relationships and health care. Health care—the care of human health—is essentially a social relationship. As Daniel Callahan defines it, care is "a positive emotional and supportive response to the condition and situation of another person, a response whose purpose is to affirm our commitment to their well-being, our willingness to identify with them in their pain and suffering, and our desire to do what we can to relieve their situation."²⁶ Care has interpersonal and institutional dimensions, both of which exist most often and most intensely in one's local community setting. At its most intimate, health care involves face to face, hand to body, caregiving practices.

This caregiving takes place within a complex set of organizational contexts that influence the "relational distance" between health care practitioners and patients and that either enhance or constrain care.²⁷ Professional caregivers typically practice within a local professional community with particular standards of practice and are members of local and state professional associations. Physicians and others are subject to legal standards regarding practitioner authority, permitted practices, and professional relations.

Local communities in the United States have long played multiple roles in health care.²⁸ Beginning about a century ago, community hospitals were established to care for local residents and train physicians. Some religious and ethnic communities set up hospitals to care for their community members who were, at times, excluded from local community hospitals. Mutual aid associations created by culturally specific immigrant groups, "fraternal" orders, and employee associations contracted with physicians to provide services to their members. This collective pooling of financial risk enabled members to receive oth-

erwise unaffordable care. Community rating served as the prototype for health insurance, which would blossom in the 1930s and 1940s. By the late 1960s, hundreds of local communities had established neighborhood health centers in response to the health care needs of low-income persons as well as the desire for community governance. Today, community-based safety net providers care for many uninsured persons, while employers are the primary providers of health plans, and thus health care, to employees.

Sick persons often receive care in communities in which they feel a sense of belonging. We tend to pay greater attention to, and have stronger moral commitments to, the suffering and needs of those with whom we share some common bond—be it shared identities, experiences, interactions, or goals. This care is clearest in groups that share strong bonds, such as some religious communities and people who have the same illness. Sheer proximity may evoke caring or a commitment to some level of attention and responsibility: a 1995 survey found that 62 percent of the American public agreed with the statement, "we have an obligation to take care of people in our local community who are in need, but not all the needy in the entire country."²⁹

Much health care takes place outside the formal health care system. Most caregiving is provided by parents (often mothers), adult children (often daughters and daughters-in-law), neighbors, friends, and other loved ones, most often in the home, though increasingly also in hospitals and nursing homes. This often invisible caring relies almost exclusively on the social networks of particular communities—familial, cultural, religious, or disease experience-oriented.³⁰ The growing number of illness-specific advocacy groups suggests that the experience of a particular condition or disease can bond otherwise strangers in their search for appropriate attention and care.

Community benefits of health care. While individual community members receive benefits from health care, communities too receive benefits. Health care institutions are integral to the institutional fabric of local community life and thus have the potential to improve community infrastructure by providing employment, training, and leadership opportunities. They also support other social institutions by helping to keep individual community members healthy and capable of participating in them as workers, students, and political citizens.

Community participation in local health care institutions, in advisory or governance capacities, can promote democratic political involvement. As such, health care institutions have the potential to contribute either to social solidarity and cohesion or to social stress and disorganization. Historically, mutual aid societies sponsored health care services for its members and as a result strengthened these communities as a whole. Community participation in neighborhood health centers has been a modestly effective means of empowering communities. Today, employer-based health insurance has been shown to build employee morale and thus promote work-based community.³¹

Benefits also accrue to the medical community from their relationship with local communities. Substantial medical training and research take place in academic medical centers located in urban and often low-income communities. These communities provide many patients and thus both educational and research opportunities to medical and other health care professionals.

Multiple and Overlapping Communities

Philip Selznick offers the following account of community: “a group is a community to the extent that it encompasses a broad range of activities and interests, and to the extent that participation implicates whole

persons rather than segmental interests or activities.”³² Groups are communities when members share common bonds of, for example, experience, interest, or place, and when members identify as community members. The more bonds and the stronger the member participation and identification, the stronger the community.

The multiple community dimensions of health care corroborate this view. Communities (and groups) are not homogeneous in belief or membership, nor are they discrete, tidy units. They are often parts of larger

□

Communities are not homogeneous in belief or membership, nor are they discrete, tidy units. Very different social collectivities with distinct membership criteria can rightfully be called communities.

□

regional, societal, national, or global social collectivities, and they have varying degrees of power, voice, and stability. Very different social collectivities with distinct membership criteria can rightfully be called communities. Member identification and participation change over time, making community boundaries inevitably porous. And most persons are members of multiple communities, which may have conflicting values and understandings about health care and other social goods.

This understanding of community, together with the multiple communi-

ty dimensions of health care, suggests two more lessons about the relationship between health care and communities. First, three general types of communities are critically involved in health and health care: local, ascriptive, and affiliative.³³ A *local* community includes everybody living within a defined geographic or political place—a town, city, or county, for example. Members of local communities share physical, social, and political environments. An *ascriptive* community is one whose members share particular “given” experiences or qualities—gender, culture, religion, social class, and discrimination, for example. These traits or experiences are often not chosen, but while they often contribute strongly to a person’s identity, they are neither essential nor immutable. An *affiliative* community is one in which members share chosen interests, concerns, or goals—a job, profession, hobby, or political opinion, for example. Ascriptive and affiliative communities often overlap depending on their members’ self-understanding; membership in a cultural community, for example, can be understood either as a voluntary choice or as a “given” born of family heritage.

The second lesson is that each general type of community makes a characteristic but not exclusive kind of contribution to health and health care. Local communities entail physical and social environments that are critically determinative of health. The social environments of local communities are constituted by the social relations within and among multiple ascriptive and affiliative communities. Environmental exposures, socio-economic conditions, social cohesion or disorganization, and health care institutions are some of the elements of local communities that affect health and health care.

Ascriptive communities, however, are particularly important as sites of health-related meaning-making, that is, as sources of understandings about health and health care. While affiliative and local communities sometimes

serve as sites of meaning-making, ascriptive communities are more likely to, and thus are more important for meaning-making. Moreover, certain ascriptive communities provide important health care institutions and social support, such as Catholic hospitals and long-term care facilities.

Certain affiliative communities, and workplace communities in particular, now constitute our primary means of obtaining health care. Joining an employer-based health plan, or some other group plan, has become a near-necessity for access to care.

Just Health Care and Communities

To recap: health care is in large measure a community good, dependent on the social relations located in local, ascriptive, and affiliative communities. It is primarily in these communities that the meanings of health and health care are created, negotiated, and shared; that people are made healthy (or sick); that care is given and received; and that the benefits of health care are accrued.

What are the implications of all this for justice in health care? Even critics of Walzer's claim that "all distributions are just or unjust relative to the social meanings of the goods at stake" affirm "the importance of attending to the values that social goods express or serve in people's lives when we develop distributive principles."³⁴ Walzer grounds this claim in his understanding that "we are (all of us) culture-producing creatures; we make and inhabit meaningful worlds. Since there is no way to rank and order these worlds with regard to their understanding of social goods, we do justice to actual men and women by respecting their particular creations."³⁵

Let us accept that justice requires (among other things) "respecting" the particular creations—the particular meanings and values—of actual men and women, not idealized rational beings. What Walzer misses is that communities give multiple meanings and

values to health care. There is no single national meaning. Given the centrality of communities to health care, communities should be recognized as legitimate, even essential, sources of normative principles of justice governing health care. Respecting these varied and sometimes conflicting community values does not reflect "high minded calls" for community involvement. It makes for a more just health care system.³⁶

The prevailing bioethical discourse about justice and health care mirrors

■

Justice requires (among other things) "respecting" the particular creations—the particular meanings and values—of actual men and women, not idealized rational beings. What Walzer misses is that communities give multiple meanings and values to health care.

■

Walzer's oversimplification, assumes a broad national consensus on health care's meaning and moral value, and then builds a notion of distributive justice on that supposition. Equality of opportunity is asserted to be a "central, widely held American ideal," "quintessentially American in its flavor," which "provides a deep foundation for a social obligation to meet health care needs."³⁷ In this understanding, health care that promotes normal functioning is understood to protect life opportunities, and health care has moral value because it helps assure equal opportunity.

Do all people in the United States really share this view of why health care is valuable? Little evidence exists of a national consensus on this or any other single meaning of health care. On the contrary, a range of community meanings and moral values exist, and to date, many of these community voices have had little effective voice in discussions of justice in health care or health care reform.

The challenges of including all communities in decisionmaking regarding justice and health care system reform are substantial. To even begin, we must determine what it means to "respect" community meanings and values. An uncritical acceptance of all meanings would be problematic as is the current neglect of community voices.

Because conflicts of meaning and value within and between communities are inevitable, we will need political processes that ensure effective community voice, deliberation, and decisionmaking. Walzer submits, "When people disagree about the meaning of social goods, when understandings are controversial, then justice requires that the society be faithful to the disagreements, providing institutional channels for their expression, adjudicative mechanisms, and alternative distributions."³⁸ Such faithfulness to disagreements, institutional channels, adjudicative mechanisms, and alternative distributions are minimally present in health care today and would need to be established.

In our deliberations about justice in health care, I suggest that local communities become the central form of health care community, for four reasons: all persons share "place" in local communities to some degree; all local communities are constituted by multiple ascriptive and affiliative communities; the boundaries of local communities are relatively stable compared to other types of community; and local communities have a long historical involvement in influencing members' health status and providing health care. But while com-

munities should be the primary context for negotiating and providing just health care, all relevant social collectivities—not only communities but families, states, and society—will need to cooperate in order to bring about just health care. Issues about community membership (who belongs), representation (who speaks), and power (who is heard and responded to) are pertinent to all social collectivities—and will need careful addressing.³⁹

Rejecting community involvement for fear of essentialism or exclusion is unacceptable. Constructive action is needed. To the extent that justice depends on the social meanings of health care, bioethicists and health care reformers must think of health care as a community good and launch any debate about just health care from within communities.

Acknowledgment

I am grateful to Gregory E. Kaebnick and two anonymous reviewers for their helpful comments.

References

1. M. Walzer, *Spheres of Justice: A Defense of Pluralism and Equality* (New York: Basic Books, Inc., 1983), 9. Here I do not adopt Walzer's entire theory of complex equality.
2. R.M. Veatch, "What is 'Just' Health Care Delivery?" in *Ethics and Health Policy*, ed. Robert M. Veatch and Roy Branson (Cambridge, Mass.: Ballinger, 1976), 129.
3. N. Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985), 10.
4. M.C. Kaveny, "Commodifying the Polyvalent Good of Health Care," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 207-223. E.D. Pellegrino, "The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic," *Journal of Medicine and Philosophy* 24, no. 3 (1999): 243-66. L.S. Cahill, "Genetics, Commodification, and Social Justice in the Globalization Era," *Kennedy Institute of Ethics Journal* 11, no. 3 (2001): 221-38.
5. S.M. Wolf, "Erasing Difference: Race, Ethnicity, and Gender in Bioethics," in *Embodying Bioethics: Recent Feminist Advances*,

ed. A. Donchin and L.M. Purdy (Lanham, Md.: Rowman & Littlefield, 1999), 70.

6. D.W. Brock and N. Daniels, "Ethical Foundations of the Clinton Administration's Proposed Health Care System," *JAMA* 271, (1994): 1189-96, at 1196.

7. Unless otherwise noted, the quotes in this paragraph and in the rest of this section are found in Brock and Daniels, "Ethical Foundations," 1189-92. Emphases added.

8. Brock and Daniels, "Ethical Foundations," 1191-1192. The authors also say, however, "To further bind us together as one community, we must remove the division between those excluded from and included in the health care system" (p. 1192). This implies, though it is not explicitly stated, that the moral ideal of community (along with equality) grounds the principle of universal access.

9. D.E. Beauchamp, *The Health of the Republic: Epidemics, Medicine, and Moralism as Challenges to Democracy* (Philadelphia: Temple University Press, 1988), 17.

10. L.R. Churchill, *Self-Interest and Universal Health Care: Why Well Insured Americans Should Support Coverage for Everyone* (Cambridge, Mass.: Harvard University Press, 1994), 58.

11. L. Payer, *Medicine and Culture: Varieties of Treatment in the United States, England, West Germany, and France*, reprint ed. (New York: Owl Books, 1996).

12. Dartmouth Medical School, Center for the Evaluative Clinical Science, The Dartmouth Atlas of Health Care (Chicago: American Hospital Publishing, 1996).

13. A. Fadiman, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* (New York: Noonday Press of Farrar, Straus and Giroux, 1997). For health care practitioners, see Park Ridge Center, "Religious Traditions and Health Care Decisions Handbook Series," (Chicago: Park Ridge Center, 1995-2001). On religious perspectives of health and healing, see *Caring and Curing: Health and Medicine in the Western Religious Traditions*, ed. R.L. Numbers and D.W. Amundsen (New York: Macmillan, 1986), and *Healing and Restoring: Health and Medicine in the World's Religious Traditions*, ed. L.E. Sullivan (New York: Macmillan, 1989).

14. R. Peel, *Health and Medicine in the Christian Science Tradition: Principle, Practice, and Challenge*, ed. J.P. Wind (New York: Crossroad, 1988).

15. Watch Tower Bible and Tract Society of Pennsylvania, "How Can Blood Save Your Life?" (New York: Watchtower Bible and Tract Society of New York, 1990).

16. S.A. Lassiter, *Multicultural Clients: A Professional Handbook for Health Care*

Providers and Social Workers (Westport, Conn.: Greenwood, 1995).

17. B.M. Ashley and K.D. O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington D.C.: Georgetown University Press, 1997).

18. J. Norsigian, "The Women's Health Movement in the United States," in *Man-Made Medicine: Women's Health, Public Policy, and Reform*, ed. K.L. Moss (Durham, N.C.: Duke University Press, 1996), 966.

19. M.A. Rodwin, "Patient Accountability and Quality of Care: Lessons from Medical Consumerism and the Patient's Rights, Women's Health and Disability Rights Movements," *American Journal of Law & Medicine* 20, nos. 1-2 (1994): 147-67.

20. I.H. Meyer, "Why Lesbian, Gay, Bisexual, and Transgender Public Health?" *American Journal of Public Health* 91, no. 6 (2001): 856-59.

21. D.L. Patrick, and T.M. Wickizer, "Community and Health," in *Society and Health*, ed. B.C. Amick III et al. (New York: Oxford University Press, 1995), 61.

22. J.S. House, K.R. Landis, and D. Umberson, "Social Relationships and Health," in *The Sociology of Health and Illness: Critical Perspectives*, ed. P. Conrad (New York: St. Martin's Press, 1997), 83-92. L.K. George, "Social Factors and Illness," in *Handbook of Aging and the Social Sciences*, ed. R.H. Binstock and L.K. George (San Diego: Academic Press, 1996), 229-52.

23. T.E. Seeman, "Social Ties and Health: The Benefits of Social Integration," *Annals of Epidemiology* 6, no. 5 (1996): 442-51.

24. I. Kawachi, B.P. Kennedy, and R.G. Wilkinson, eds. *The Society and Population Health Reader*, vol. 1, *Income Inequality and Health* (New York: The New Press, 1999); Patrick and Wickizer, "Community and Health."

25. F.W. Young and T.A. Lyson, "Structural Pluralism and All-Cause Mortality," *American Journal of Public Health* 91, no. 1 (2001): 136.

26. D. Callahan, *What Kind of Life: The Limits of Medical Progress* (New York: Simon and Schuster, 1990), 144.

27. R.A. Scott et al. "Organizational Aspects of Caring," *The Milbank Quarterly* 73, no. 1 (1995): 77-95.

28. M. Schlesinger, "Paradigms Lost: The Persisting Search for Community in U.S. Health Policy," *Journal of Health Politics, Policy and Law* 22, no. 4 (1997): 937-92.

29. Schlesinger, "Paradigms Lost," 996.

30. L. Levin and E. Idler, *The Hidden Health Care System* (Cambridge, Mass.: Ballinger, 1991).

31. W.A. Rushing, *Social Functions and Economic Aspects of Health Insurance* (Boston: Kluwer-Nijhoff, 1986), 166-67.

32. P. Selznick, *The Moral Commonwealth: Social Theory and the Promise of Community* (Berkeley: University of California Press, 1992), 358.

33. My thanks to Mark Schlesinger for suggesting this typology.

34. A. Gutmann, "Justice across the Spheres," in *Pluralism, Justice, and Equality*

ed. D. Miller and M. Walzer (Oxford: Oxford University Press, 1995), 103.

35. Walzer, *Spheres of Justice*, 314.

36. D.S. Davis, "Groups, Communities, and Contested Identities in Genetic Research," *Hastings Center Report* 30, no. 6 (2000): 39.

37. N. Daniels, D.W. Light, and R.L. Caplan, *Benchmarks of Fairness for Health*

Care Reform (New York: Oxford University Press, 1996), 19-20.

38. Walzer, *Spheres of Justice*, 313.

39. C.A. Galarneau, "Communities Obscured: Justice in Health Care," Chapter 7 (Ph.D. diss., Harvard University, 1998). Davis raises these issues in relation to research in "Groups, Communities, and Contested Identities."