Reading SAL Week 15: Justice and Health Care

Stein brook: Imposing Personal Responsibility for Health (2006)

There's an assumption that if we live right we'll live longer and cost less. As a result there are various strategies being implemented which correlate care with patient behavior. There are some questions: What measures actually make a difference? Which measures only shift the cost to patients?

This article discusses a West Virginia initiative that ties medical support to patient behaviors. There is a basic (quite restricted) program; for a program with, for instance, unrestricted pharmaceuticals, the patient must commit to various requirements: keeping appointments, compliance with medications, attending prescribed "health improvement" programs (ie, smoking cessation, diet, exercise).

Cappelen and Norheim: Responsibility in Health Care (21005)

This article raises questions about the appropriateness of correlating the distribution of the costs of healthcare with patient behaviors. Should the priority of treatment for a disease depend on the extent to which the disease is the result of individual choice?

To hold someone responsible is to link either the relative payment for the treatment or the length of the treatment to factors which are under the control of the individual in question. Accountability policies are justified both by backward looking considerations (=people are responsible for the consequences of their choices) and forward-looking considerations (=disincentivizing damaging behaviors).

Normative objections: Nevertheless this approach is underutilized. Why?

(a) Humanitarian objection: we should aid people in need, without inquiring how they got there.
(b) Liberal objection: health is so important to other social functions that it has some kind of primacy as a precondition for other rights.
(c) Fairness objection: not all disease producing factors—even those most proximate—are within our control. Such policies have the effect of blaming people for luck.

Practical objections:

(a) Informational objection: Not everyone has the same access to information about what is and what is not correlated with various diseases. (And if physicians are the people responsible for determining accountability, patients will not tell them about their actions.)
(b) There is a great deal of uncertainty about the causal connection between various behaviors and diseases
(c) Neutrality objection: what kind of behaviors, what causal factors, will be considered relevant for punitive action? Is drinking more to be punished than drugs? Is diet more to be punished than smoking?

Liberal egalitarianism, our authors claim, avoids most of these objections. A central goal of public policy should be to secure equal opportunity for all. Society should eliminate or compensate for inequalities arising from factors which are out of an individual's control: like differences in genetic endowments or natural abilities.

> "All individuals who make the same choices should be treated as if they were identical with respect to factors out of their control." (p. 259)

At the same time, we want to hold people responsible—not for the consequences of their choices, but for those choices. Luck does enter as a determinant of consequences.

So for instance—tax the *activity*. For instance: tobacco taxes to pay for healthcare.

Problems:

(a) How do you determine what is and what is not under individual control?
(b) There are other factors than choice (ie, socio-economic factors) that determine behaviors
(c) Not all contributions to poor health are readily taxable.

Dwyer: Illegal Immigrants, Health Care and Social Responsibility (2004)

This article asks: Does society have an ethical responsibility to the undocumented among us? Dwyer assumes that it is uncontroversial that societies do have a moral obligation to provide their own citizens with reasonably comprehensive health benefits. But the extent to which that obligation extends to people who are not citizens is more controversial.

History: the Athenians only tried to control citizenship, but did not worry about residency. The US today not only limits citizenship, but attempts to control residency as well. There are somewhere between 5 and 8 million undocumented aliens in the US, 40% of whom entered legally and overstayed their visas. In Europe, 1/3 are probably illegal; in Israel, 1/5…

The US in 1996 passed the Illegal Immigration Reform and Responsibility Act, according to which illegals are not eligible for Medicaid, although states will be reimbursed for the amount spent on emergency treatment.

In 1994 California voters passed Proposition 187 by 59%. It would have denied healthcare, social services and educational access to undocumented workers. (It never went into effect.)

In the context of this history—and in the face of the fact that illegal immigrants are the people who are most likely to be exploited and neglected—in what ethical frame can we put the society's obligation to their health care?

Desert?

> Given the limited public budget for healthcare, are citizens and legal aliens more *deserving* of healthcare than illegals?

Dwyer suggests that 'desert' or social merit seems a more appropriate criterion for things that are not basic needs—things for which the criteria of achievement and effort are more clear, like prizes for the best chemistry student or something.

Illegal immigrants do pay taxes, as well as contributing in other ways to the polity. It is inappropriate to ask whether they pay enough in taxes to cover the cost of the services they use; we shouldn't run the government like a business.

Professional ethics?

Lo and Ziv argue that cooperating with restrictive measures like prop 187 would undermine professional ethics. They suggest two reasons: not treating undocumented workers could have a negative effect on public health, thus affecting the health of citizens

as well. But as well, undocumented workers are part of the public; health services for the public should meet their needs. (=Dwyer's appeal to social justice)

Another complication of 187 was that it put the healthcare community in the position of being an arm of the immigration service, which is always a bad idea. The physicians need to concentrate on the medical needs of their patients, not their immigration status. *(Cf. Scandal in SC when pregnant women were incarcerated for drug use)*

Dwyer's problem with this defense: should patient selection be based only on medical need, which Lo/Ziv seem to suggest? If so, there should be no private practice medicine, all national health plans are too restrictive, transplant lists should be open to everyone world-wide, and probably lots of doctors should leave the suburbs and move to central Africa. He suggests a middle ground: society should provide all its members with basic health care; and doctors should work toward that social reform.

Human rights?

National boundaries are indeed to some extent historical accidents, arbitrary. But there is a qualified justification for them to that extent that they allow for collective action. And this includes a qualified right to regulate immigration, insofar as its attempts to do so do not involve injustice in the means, and treat the immigrants themselves appropriately.

Paul Farmer (one of my favorite culture-heroes) is quoted on p. 279: there is a lack of proportion between medical resources and the burden of disease. But Farmer, Dwyer claims, also believes in something like human rights that include equal access to health care; and Dwyer is skeptical about the usefulness of 'rights' language in this context: "Claiming that all human beings have a right to health care is easy. Specifying the kind of care to which people are entitled is harder. Specifying duties is harder yet. Getting those duties institutionalized is hardest of all." (p 279)

Dwyer's preference: specify modest human rights, and supplement that with an account of social justice and responsibility.

Social responsibility!

With ethical conviction and political will, we could transform the working conditions of the immigrants among us, empower the most disadvantaged workers, and shape the background conditions of the labor market. Providing health care is a good way to improve the benefit workers receive for their labor; render them less vulnerable to other abuses; and convey to them the respect they earn for their contribution. The issue should be framed in the language of social justice and social responsibility (not 'rights').

Arras: Rationing Vaccine

This article draws a contrast between the rationing decisions appropriate for a normal flu season (interpandemic flu) and those more probable in the case of a pandemic. He assumes that even in normal years, the practicalities of getting sufficient vaccine to protect the population makes rationing necessary—and that is true nationally, even without taking into consideration international requirements. But he suggests that the ethical principles currently applied to this question are inadequate.

I: Interpandemic: Current practice decrees we protect those most at risk for mortality and hospitalization: people over 65, people in institutions, people with other illnesses that make them susceptible, children from 6 to 23 months, and pregnant women.

Recently protection of healthcare workers, and caregivers for children under the age of 6 months have been suggested as other groups who are potential vectors for infection.

The consensus on these priorities means that we haven't really had to develop principles of distribution, although he notes that some communities have set up other distribution policies—ie, first come first served, or distribution by power of access (either money or political pull)—which he considers both unethical and unnecessary.

Local distribution Arras considers an acceptable option under normal flu, and he notes that market principles are compatible with less serious flu seasons, noting that sometimes private (or government) enterprises order in advance and pay, and it is inappropriate to penalize them for foresight. But if the flu is worse than usual, that gets problematic.

II: Rationing during a pandemic:

If we ever do get a pandemic, there will be less room for the operation of the free market. Under those circumstances, the central government should have more control, although it is not necessary to control distribution through government sites only; the normal appropriate venues can be utilized.

Principles of rationing:

1—protect the most vulnerable

2—protect key personnel in health care, public health and safety, and crisis response infrastructure

3—protect key social functions: trucking, police and fire, national guard, funeral directors

4—maximize for economic benefit: air travel, telecommunication, food production and distribution

5—under conditions of pandemic, we may wish to "maximize 'fair innings.'" Arras does not expand on this, but I think he agrees with the suggestion of Emanuel and Wertheimer, below, which would mean protecting the 20-35 year olds, rather than the very young (who don't have life-projects yet to fulfill) or the very old (who have had their chance to fulfill their life projects),

III: Difficulties of pandemic rationing:

The various policy goals I have outlined are not necessarily mutually compatible. The most vulnerable are also the least socially valuable; giving vaccine to them would not be the most efficient use of the scarce resource. Also, we don't have, and never will have, sufficient information to prioritize them.

Daniels and Sabin think that fair procedures are the only just substitute for a consensus on priorities. Arras suggests that special attention should be paid to be sure we don't overlook the needs of those already most disadvantaged, the poor and minorities. He would also like to pay some attention to issues of global justice (see Paul Farmer, above); but it's hard to see how his principles of rationing allow for that.

Emanuel & Wertheimer: Who Should Get Flu Vaccine? (2006)

Some possible ethical principles by which to allocate resources:

--save the most lives (NVAC & ACIP)

--women and children first

--first come, first served
--save the most quality-life-years
--reciprocity
--save the most likely to recover
--save those instrumental in social flourishing

E&W think that the most appropriate approach is a life-cycle allocation: each person should have the opportunity to live through all the stages of life. With this in mind, they recommend a modified version of the 'life-cycle allocation' which does not go by pure chronology, but balances the amount invested in one's life by the amount of time left to live. (=a 20 year old is more valuable than a 1-year old).

Protecting public order is very important in a pandemic. *(Some question, based on our past experience of how governments react to crises, whether the national guard is there to protect you and distribute meds, or to lock you in your house so you won't spread the disease…)*