Health Care Distribution

Health care in this country is a problem. Nearly 50 million Americans (8 million children) are uninsured; and we're not talking homeless people. 75% of the uninsured are members of steadily employed families. Part of the problem is that health care in the U.S. is incredibly expensive—way more than any of the other richer nations. We spend around $8000 per person, per year. Meanwhile, Canada spends around $4000, the UK and Japan, $2000. The result is that between 20,000 and 30,000 people die prematurely each year as a direct result of not having health coverage (26,100 in 2010). On top of that, our infant mortality rate is higher than that of any other developed country, and our life expectancy is lower than the developed country average.[1]

So, the question is, What do we do? Do we have a RIGHT to some amount of health care? If so, is it the government's responsibility to ensure that we receive it?

1. The Nature of Rights:

(1) What a right is: A right is something that one has a claim to. To say that I have a "right" to X means that I am ENTITLED to X, or that X should be granted to me.

(2) Rights vs. Utility: Ethicists generally believe that, if rights exist, then they can "trump" considerations of maximizing utility. For instance, if I have a right to my own body, but the greater good would be maximized by killing me and harvesting my organs, it would still be WRONG to harvest my organs, because my right to my own body is STRONGER than (i.e., "trumps") the greater good. (So, utilitarians can never believe in "rights" in this very strong sense).

(3) Positive vs. Negative Rights: Rights come in two varieties. Positive and negative. If I have a negative right to X, then it means you should NOT do something to violate this right. For instance, if I have a right to life, this is a negative right because it means that you should NOT kill me. On the other hand, if I have a positive right to X, then it means that you SHOULD do something to/for me. For instance, my right to health care is a positive right because having it entails that someone SHOULD provide me with health care.

(4) The role of the government: It is generally held that, if I have a right to X, then the government's role is to ENFORCE this. For instance, if I have a right to my own property, the government should punish those who try to take my property away. Similarly, if I have a right to a minimum amount of health care, then the government ought to try to ensure that I receive it.

[1] See: http://www.oecd.org/health/health-systems/49084355.pdf

2. The Libertarian View of Health Care:

Libertarianism: Recall that libertarians (entitlement theorists) like Nozick deny the existence of most (or all) positive rights. We have a RIGHT to our own property, and no one can demand that we give up some of them, even if doing so would heal them, or save their lives. If the government were to try to ensure that everyone had access to some minimum amount of health care, this would involve re-distributing wealth in such a way that some people's tax money would go toward the care of others. Such a practice, according to the libertarian, is rarely (never?) justified. (of course, people could still freely choose to participate in a privatized insurance program which essentially does the same thing)

Objection: In the unit on Nozick, we raised several objections to this view. Most importantly, it seems that, in matters of life and death, perhaps we who can help ARE morally obligated to sacrifice a little in order to save the lives of others.

3. The Utilitarian View of Health Care:

Utilitarianism: Utilitarians are often in favor of giving health care to all. Why?

(a) People who aren't suffering are better able to contribute to increasing utility.

(b) People who know their health care is covered feel more secure, and this promotes a happier, more cooperative society, which better maximizes utility.

(c) The theory of "**Diminishing Marginal Utility**" recommends helping the needy. This is the idea that, the more you have of something, the less happiness more of it will give you. For instance, if you have zero candy bars, giving you one will make you very happy. Giving you a second one will make you a little happier. But, if you have a HUNDRED candy bars, giving you one more will not matter to you very much. To see the truth of this, just ask: If you had one hundred dollars to give to someone, who would it be better to give it to? Bill Gates, or a homeless person? With this theory in mind, the utilitarian is often in favor of wealth re-distribution. In short, the rich can give up a little, which doesn't benefit them very much, so that the needy can rise a LOT.

Objection to Utilitarianism: We looked at several objections to utilitarianism. Most importantly was the idea that, strictly speaking, utilitarians do not really believe we have "rights" at all, and therefore no one has a "right" to health care. For instance, if some other project came along, which showed the prospect of maximizing utility more efficiently, we should do so (e.g., euthanizing those without insurance and stealing their organs to give to others). However, a lot of people think that we ought to save someone

with an expensive treatment, or a life-long (and ultimately expensive) treatment, even if that person will not become a fully productive member of society, or if the "**cost-benefit analysis**" ends up in the red.

4. QALY-fying Life: The true "cost-benefit" nature of utilitarianism comes to light when we examine the popular proposal for health care distribution called QALY.

> **QALY:** "Quality-Adjusted Life Year". This is a method of quantifying the value of a life. Count one year of a healthy life as having a value of 1. Count being dead as having a value of zero. Count one year of suffering as having a value of -1 (negative).

The suggestion of QALY theorists is that the distribution of health care should follow in accordance with what promotes the greatest amount of life quality while having the lowest cost. So, high priority treatments would be one where the cost-per-QALY is low, while low priority treatments would be ones where the cost-per-QALY is high.

This sort of calculation sometimes makes sense; e.g., when trying to decide which of 2 treatments to give a patient. However, QALY is meant to decide much more than that:

(1) QALY will sometimes dictate which of 2 patients to treat.
(2) QALY decides which sorts of medical conditions get priority and which do not.

So, ultimately, this is a utilitarian proposal (because it is about maximizing efficiency and benefit). Now, utilitarians are in theory in favor of universal health care—but QALY would not recommend TRULY UNIVERSAL health care, since, in a system where resources are not infinite, some patients must be denied treatment in favor of others.

Objections: Harris asks us to imagine that we have 6 patients, but only enough supplies to either: (a) Give the first 5 people a treatment that will put their sickness in remission for 1 year. Or (b) Give the 6th person a treatment that will put her sickness in remission for 7 years. QALY would say that I am OBLIGATED to treat the 6th person and let the other 5 people die. Harris believes this verdict to be patently false. [Is it? What do you think?]

Why does he think this is a bad verdict? Harris says this sort of mentality **fails to value individual lives**. It makes us see people as numbers rather than as PEOPLE. We have a basic intuition that all people should be valued equally, and everyone should be given equal weight. And furthermore, that our HEALTH services should abide by this belief; i.e.,

> "the belief that the life and health of each person matters, and matters as much as that of any other and that each person is entitled to be treated with equal concern and respect…" (743)

QALY doesn't give equal weight to individual people, but rather to individual QALY's. This de-humanizing perspective of QALY has some terrible implications:

(1) **Ageism**: In many cases, distribution of treatment will give preference to the young, since they have more years ahead of them. (for instance, any treatment that saves a life)

(2) Racism and Sexism: If it turns out that certain treatments are statistically more successful for a certain race or gender, that race or gender will be given PREFERENCE over others.

(3) "Worthless" Lives: Some people might be seen as "not worth" treating; for instance, someone who was in a terrible accident, and could be saved, but would be paralyzed from the waist down—QALYs may recommend letting them die.

(4) Skewed Priorities: We typically think that, other things being equal, a treatment that saves a life is better than one that simply improves the quality of one's life. QALYs makes no such distinction, and in many cases might even recommend a procedure which improves a life over one that saves a life. For instance, Harris cites a study in Britain which claimed that £200,000 could get 10 QALYs if spent on kidney dialysis, 266 QALYs if spent on hip-replacement surgeries, and 1197 QALYs if spent on anti-smoking propaganda. Should we, then, forbid dialysis (and hip replacements) in light of this?

(5) Relief Aid: It could give the result that we should completely ignore, say, the people affected by Hurricane Katrina, and instead give medical aid to malnourished children.

(6) Procreation: Here's one final thought: If we should be maximizing QALY's, then should we ban abortion and contraception, and all be procreating right now?

We have a basic intuition that each life is equally valuable. Each life is worth "one". But QALYs makes it such that some lives are worth more than others. If each life is equally valuable, then we ought to treat each person with equal concern and respect. But, then, the GOVERNMENT also ought to treat each citizen with equal concern and respect—including some standard of health resource allocation; in short, it must not choose between individuals, or allow others to make choices between individuals, which involve a violations of their basic human rights, or which result in a failure to treat all human beings as equals. He says, if I am less healthy, less fit, have less money, fewer friends, fewer lovers, fewer children, less life expectancy, or less of the things that I want in life,

> "it does not follow that others are entitled to decide that because I lack some or all of these things I am less entitled to health care resources, or less worthy to receive those resources, than are others, or that those resources would somehow be wasted on me." (744)

Argument By Analogy: He also proposes something like the following argument:

1. It would be morally wrong to adopt a rubric which allocated **justice** (e.g., fair trials) only to those for whom justice could be provided cost-effectively.
2. But, allocating health care according to a rubric which issues health care only to those for whom health care could be provided cost-effectively (e.g., QALYs) is morally analogous to this.
3. Therefore, it would be morally wrong to adopt QALYs as a rubric for health care distribution.

[Objection: Does the difference have to do with positive vs. negative rights? Failing to give health care equally is failing to **benefit**. Meanwhile, failing to give a fair trial might result in unjust incarcerations, in which case we fail to refrain from **harming** someone.]

National Defense: The QALYs proposal makes some harsh calls because resources are SCARCE. We cannot afford to give EVERYONE EVERYTHING they need, medically. But, Harris denies this. He calls attention to how much the government spends on national security and defense (about $700 billion each year). We spend the most on national defense, he says, but health care IS an issue of national defense—against DEATH and DISEASE! [What he fails to acknowledge, however, is that the U.S. government spends even MORE taxpayer money each year on health care (about $1,100 billion each year). Health expenses are the #1 expenditure of taxpayer dollars, and defense is #2. See here.]

5. The Rawlsian View of Health Care: According to Daniels, what matters with equality is equality of OPPORTUNITY. As Rawls stated, everyone should have the same opportunities (for instance, any inequalities must be the result of achievements that are available to all). Disease and disability restrict our opportunities. So, health care should be concerned with restoring equality of opportunity.

However, since resources are limited to varying degrees in different nations, the EXACT nature of the system will be relative to each society, based on the resources they have available, etc. Since resources are limited, the right of patients should restricted only to some MINIMUM standard of BASIC or NECESSARY universal health care.

What counts as a "necessary treatment"? Certainly, this will include commonplace treatments that are known to be highly effective—EVERYONE should have access to these. But, medical technology is constantly advancing, such that we are able to cure

more and more disabilities and illnesses. All of this cutting-edge technology is incredibly expensive and sometimes not entirely effective, however. Should EVERYONE have access to these sorts of treatments? Daniels says no.

How to Judge Necessity: Daniels proposes that we judge something to be a "basic" or "necessary" treatment if it:

(1) promotes equality of opportunity (e.g., by promoting health, or normal functioning)
(2) is highly effective
(3) has a relatively low cost (or, is at least cost-effective)
(4) is widely available

Clearly, something like cosmetic surgery (for purely cosmetic reasons) would not count as "necessary" since it does not correct for a restriction in opportunity or normal functioning. On the other hand, something like life-saving antibiotics WOULD count.

[Objections: (1) Could a case be made that cosmetic surgery IS "necessary" in this sense? What if someone is obscenely ugly? Won't this disability seriously hinder their opportunities in life, such that we are obligated to bring them up to a normal level?

(2) Daniels likens Prozac to cosmetic surgery too. Is it REALLY true that no one NEEDS Prozac in order to "function normally" or have "equal opportunity" for success?

(3) If someone is extremely brilliant, or skilled, or beautiful, should we HINDER them? Their natural traits will give them FAR more opportunities than everyone else. How is equality of opportunity sustained if some people are naturally more gifted?]

The hardest issues, he says, will fall somewhere in between cosmetic surgery and simple, life-saving treatments like antibiotics. For instance:

(1) Abortion. It's not a treatment that promotes equal opportunity or normal functioning… Or is it?
(2) In-Vitro Fertilization for sterile partners. Sterile people aren't "normal functioning", but this "treatment" is costly.
(3) And what do we do in cases where we are deciding between, say, administering a treatment that gives a GREAT benefit to a FEW people vs. one that gives a MODEST benefit to a LOT of people?

6. Options: We seem to have several choices for national health care:

(1) Canada's Method: Provide all health services to all people, but no extra insurance is allowed. So, "non-basic" treatments will have lotteries or long waiting lines.

(2) Britain's Method: Providing all services to all, but allowing those who can afford it to purchase additional insurance which will get them faster or better treatment when there are long lines.

Option (1) certainly establishes equality of opportunity with regard to health care. It may seem as if (2) destroys equality of opportunity, but remember that the additional wealth has come from jobs which were, presumably, available to all. It does seem that we should allow people with excess money to spend it on whatever they want—so why would we exclude expensive medical treatments from "whatever they want"?

A third option (sort of like Obama's proposal for the U.S.) is:

(3) U.S. Method (under Obamacare): Most people must buy insurance; only the very poor fall under the care of the government program (where their health care or insurance is subsidized).

Daniels points out that (3) might promote resentment or inequality. But, if not (1) – (3), then we are left only with option (4):

(4) The U.S. Method (prior to Obamacare): 80% of people can afford health care/insurance. The other 20% are without insurance. The very poor are never denied emergency treatment, but non-critical emergencies are left untreated. About 25,000 people die each year due to this.

Clearly, the fourth option does not preserve equality of opportunity. So, Daniels would be against the pre-Obamacare system (or an even worse proposal which denies the poor even emergency treatment).

[Objection?: If we allow the rich to spend their excess wealth on whatever they want (rather than heavily taxing it and re-distributing it), presumably because they earned that wealth based on some opportunity that was available to all, then what about the very poor? Many claim that the very poor "earned" their poverty based on poor decisions that were equally available to all. If the rich get to live with their inequalities, do the poor as well? What did the article by Ben Hale have to say about this thought?]

[Note: Daniels is "Rawlsian" but fails to mention the veil of ignorance. If you were behind that veil, what sort of distribution of health care would you choose?]