

Medical Humanities Report

Fall, 1993

Individual Responsibility for Health and the President's Health Security Plan

By Dorothy E. Vawter, Ph.D.

Individual Responsibility for Health

The President's Health Security Plan was hammered out amidst a chorus of claims that individuals should be held responsible for their health. Many administration officials, state lawmakers, physicians, employers, insurance companies, and members of the public are convinced that individuals should in some way or other, for one reason or another, be held responsible for their health. There are calls for health education and wellness programs, taxation of risky behaviors, higher premiums and/or higher fees for persons who engage in risky behavior, and the denial of health care services to risk takers. Whereas some of these proposals simply seek to empower individuals to take greater control of their health, others actively seek to modify health behaviors, prevent individuals with risky lifestyles from financially harming those with healthy lifestyles, and/or punish those who take voluntary health risks by requiring them to suffer the adverse, but treatable, consequences to their health. This is not the place to fully evaluate the various conceptions of individual responsibility. However, it is worth considering which conception inspires *The President's Health Security Plan* and the role it plays in the Plan.

The President's Health Security Plan

The primary ethical objective of the President's Health Security Plan is to provide

universal access to comprehensive quality care on the basis of need. The Plan seeks to redirect the fundamental ethical commitment of our health care system to distribute health care on the basis of health need, rather than continue to distribute care on the basis of ability to pay, geographic location, and other morally irrelevant factors. Conceptions of individual responsibility that permit charging more for health care coverage and/or health care services, or that permit denying health services altogether, are inconsistent with traditional understandings of "health need" and the distributive principle "to each according to his or her health need." They entail radically altering our understandings of these concepts.

According to some conceptions of individual responsibility, those "health needs" which can be traced to voluntary behavior do not generate a strong claim, or any claim at all, to health care. Only claims generated by health needs that cannot be traced to an individual's voluntary behavior constitute a genuine health need. On this view, insulin, for instance, might not be considered needed, but merely desired, by a patient who has diabetes and is "unwilling" to control his diet.

The conception of individual responsibility in the President's Plan clearly rejects distributing health care according to the patient's responsibility for his or her needs. Individual responsibility is understood to entail voluntary obliga-

(Responsibility continued on page 2)

Responsibility (cont.)

tions, and does not justify imposing financial, medical, or moral penalties. In my view, the conception of individual responsibility for health embraced by The President's Health Security Plan is the only conception consistent with the Plan's fundamental ethical commitments to universal access and the distribution of health care according to health need, in the broad, traditional sense.

The following passages from the President's Health Security Plan provide important insight into the Plan's conception of individual responsibility for health.

° No health plan may deny enrollment to any applicant because of health, employment or financial status nor may they charge some patients more than others because of age, medical condition or other factors related to risk.

° Every American citizen and legal resident should have access to health care without financial or other barriers.

° The system should avoid the creation of a tiered system providing care based only on differences of need, not individual or group characteristics.

° Health plans accept every eligible person enrolled by an alliance without regard to individual characteristics, health status, anticipated need for health care, occupation, affiliation with any person or entity.

° Under health reform, each individual and family should assume responsibility for protecting and promoting health and contributing to the cost of care. [The White House Domestic Policy Council, *The President's Health Security Plan: The Clinton Blueprint* (New York, NY: Times Books, 1993) pp. 6, 11, 12, 81]

The individual's obligation to protect and promote health is understood as a personal responsibility that individuals ought to assume on their own accord. This conception of individual responsibility assumes no more than that people have some control over a number of behaviors that affect health, and that it makes sense to expand health education and promotion programs to assist and encourage people to make informed

decisions regarding their health related behaviors. The focus is exclusively on voluntary methods of encouraging greater personal responsibility for health. This conception deliberately and wisely chooses not to go further and hold individuals morally culpable and/or financially responsible for failure to engage exclusively in healthy behaviors.

Cigarette Tax

The President's Health Security Plan presents only the basic structure of the health care system the President envisages. Details concerning the implementation of the plan are yet to be fully described. In several speeches, including his speech before the joint session of Congress, President Clinton indicated that he favors taxing cigarettes as a method of generating the money necessary to fund his reform program. This is a common policy proposal, which in most instances stems from conceptions of individual responsibility at odds with the one in *The President's Health Security Plan*. While Clinton seems to avoid justifying the proposed cigarette tax in terms of individual responsibility, the tax may nevertheless conflict in important ways with the plan's conception of individual responsibility insofar as it may conflict with planned programs to educate and encourage individuals to stop or avoid using tobacco.

While Clinton's proposal to tax cigarettes may be a politically feasible and fruitful method of raising funds to pay for the new health care plan, clearly it does not rest on any principled argument concerning individual responsibility for health. The government is not justifying singling out tobacco use for taxation on grounds that smoking is voluntary. Rather, the Surgeon General reports that tobacco can be eight times more addictive than heroin. Tobacco use is not being singled out because the government has

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tried every other means of discouraging it. The government still subsidizes the cultivation of tobacco and has few restrictions on advertising. It is not being singled out because physicians have long been trained in and committed to patient education and programs directed at substance abuse. Few medical schools provide students with substantive training in the diagno-

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sis, education, and treatment of patients who engage in addictive behaviors. It is not even being singled out because tobacco users cost tax payers more than non-users. Researchers estimate that smokers cost the government less over a life time than non-smokers. Nor is it being singled out because tobacco use is a behavior engaged in primarily by those with the greatest resources available to alter their lifestyles or pay additional taxes. Rather it is used primarily by socially and economically disadvantaged members of society. This, in addition to tobacco use being a socially frowned upon behavior, makes it politically feasible to impose a hefty tax on the behavior.

The proposed tax might be consistent with the President's health reform plan if the tax were calculated on the basis of the revenue needed to fund successful anti-smoking and cessation programs and if the revenue collected were earmarked for such programs. The success of the tax in this case would be measured in terms of the decrease in both tobacco consumption and the taxes collected. As the need for such programs declined, so would the taxes collected. A cigarette tax of this kind, however, clearly cannot raise revenue to fund new health care programs.

There is no indication that President Clinton plans to earmark the cigarette tax for programs to encourage individuals to abstain

from or reduce tobacco use. Instead he proposes that the tax be calculated on the basis of the money needed to pay for the health reform plan. A \$.75 tax on every pack of cigarettes is calculated to generate between \$65 and \$70 billion dollars over a five year period. A cigarette tax designed to increase the revenue needed to support valued parts of our health care system,

parts that are unrelated to promoting tobacco-free lifestyles, would seem to conflict with the basic objectives of the President's plan. Since we as a community will come to depend on the tax from cigarettes to support our health care system we will need smoking to

continue and may be displeased should tobacco use decline. Therefore, the tax may ultimately, even if only indirectly, lead to the encouragement, rather than the discouragement, of tobacco use. Should this occur, the proposed cigarette tax would conflict with plans to encourage individuals to take responsibility and adopt tobacco-free lifestyles.

Conclusion

As the President's Plan is debated in Congress, and as the plans for implementing the reform plan are worked out, I believe it is extremely important that health care reform retain the conception of individual responsibility for health that supports voluntary health education programs and access to health care on the basis of need. If this conception changes, we can expect to lose the accompanying commitments to universal access, to permitting different premiums based only on difference in the ability to pay, and to prohibiting health care plans and health professionals from refusing to accept and treat a patient on the basis of his or her anticipated health needs or personal responsibility. There is great fairness, not to mention wisdom and compassion, in substantially expanding our education and health promotion programs while refusing to hold individuals morally and financially responsible for their health behaviors and/or any associated health needs.

Health Care in A Welfare State: Medical Ethics and Health Policy in Norway

By Peter Vinten-Johansen, Ph.D.

July 5 - August 8, 1994 --- Since 1936, when Marquis Childs described Sweden as "the middle way" between capitalist and communist countries, outsiders have been intrigued by the Scandinavian welfare states. Their staunchest adherents speak of a Scandinavian model of realistic equity among social groups--involving extensive social services and transfer payments, managed economies, and moderating behavioral controls on individuals. Critics of the Scandinavian model, however, argue that substantial income redistribution, cradle-to-grave provisions, extensive state regulation of the marketplace, and Janteloven have blunted individual incentive, promoted the growth of a meddling bureaucratic elite, and unduly rewarded mediocrity. But do public policies that emerged from the context described by Childs have relevance for a post-modern age in which it is frequently alleged that socialist principles have been routed by triumphant capitalism? That is, does there still exist a need for "the middle way"?

These are among the fundamental questions to be explored in Norway during a five-week program in the summer of 1994. The goal is to advance our understanding of the U.S. health care system at the same time that we study health care policy in the Scandinavian welfare states, particularly Norway. The program framework is interdisciplinary, integrating perspectives from history and philosophy. We will analyze the historical evolution of the Norwegian welfare state, focusing on the modification of initial principles in health care policy in response to changing socio-political, cultural, and economic conditions. As such, this study of historical trends exposes changing moral concerns about social justice and equity and, therefore, makes an interdisciplinary connection to medical ethics.

MAJOR TOPICS

- (1) The welfare-state concept in 20th century Europe, with the focus on Scandinavian welfare states and, narrower still, Norway.
- (2) An introduction to medical ethics, including fundamentals of effective ethical reasoning, healer-patient relationships, informed consent, resource allocation, and competing notions of social justice.
- (3) Ethical issues in formulating public health and health care policies in a country composed of geographically diverse regions and decreasing ethnic homogeneity.
- (4) Problems in international comparisons of health care systems.

LOCATION AND PROGRAM ACTIVITIES

Our institutional home base will be the Center for Medical Ethics--a national center for research and teaching--at the University of Oslo. The Center is a short walk from the tram line that participants will take from their accommodations at the Kringsjå studentby (student village) in the northern outskirts of Oslo. Housing is in single rooms, with two students sharing a shower and eight sharing a common kitchen; self-catering is encouraged to reduce the cost of meals. Hiking trails begin almost at one's doorstep. The tram line provides ready access to downtown Oslo.

Seminars are primarily interactive, utilizing small-group discussion of readings, field experiences, and presentations by outside speakers. Guest speakers will represent a variety of perspectives--policy makers and administrators, nurses, physicians, students, scholars, and patients. Though the language gap rules out individual visits with primary care providers, some speakers will use videotaped clinical encounters in their presentations, with critical segments translated. We will make site visits to a variety

of health care and social service institutions in greater Oslo, including Helsedirektoratet (The Bureau of Health), Rikshospitalet (The National Hospital), elder-care facilities, social medicine units, and sports medicine institutes.

During one week of the program, we will travel to other parts of Norway. The tentative itinerary begins with a flight to Troms (above the arctic circle) for an overview of primary care training program at the university, plus visits with practitioners serving the Sami peoples and others living in isolated regions. Then we fly to Bergen, where we will visit primary care facilities, including what is available on some off-shore islands, as well as the regional hospital and medical school. We will also view past practices at a reconstructed leper clinic. Most probably, we will return to Oslo by train across the mountains. The purpose of this week is to assess attempts at adapting welfare state principles and health care policies to diverse geographical conditions, demographics, and ethnicity.

ACADEMIC PROGRAM

The program is designed to suit a broad range of participant backgrounds, including undergraduates, graduate-professional students, and individuals already employed in social policy and health care sectors. There are no specific academic prerequisites for participation. English

will be the language of instruction in seminars and field experiences; although most Norwegian speakers scheduled to meet with us are fluent in English, the instructors will translate, when necessary.

INSTRUCTORS

Reidar Lie, M.D., Ph.D., is Professor of Medical Ethics at the University of Oslo and Director of its Center for Medical Ethics. His current research interests include ethical issues in clinical trials and philosophy of medicine. He is co-formulator of this first program offering.

Peter Vinten-Johansen, Ph.D. is Associate Professor of History and Director of Interdisciplinary Programs in Health and Humanities at Michigan State University. His current research interests include Scandinavian intellectual history, medical education, and comparative health care systems. He taught Medical Ethics and History of Health Care in London five times (1986-90), and is co-formulator of this first offering in Norway.

For a complete brochure and application packet, please contact: Peter Vinten-Johansen, Director Interdisciplinary Programs in Health and Humanities (IPHH) 318 Linton Hall Michigan State University East Lansing, MI 48824-1044 Telephone: (517) 336-2691 FAX: (517) 336-1858 E-MAIL: 21798PVJ@MSU.EDU

Medical Ethics and History of Health Care in London

By Brian Brown, M.A.

I am pleased to announce that our ninth annual London summer course will take place July 6 through August 11. Joining me as co-director this year is Judy Andre of the Center for Ethics and Humanities in the Life Sciences. Both of us are keen on spreading the word about the program and we hope readers will help. Talk it up, folks!

Debate over the Clinton Health Plan and its competitors makes our program more relevant than ever. The British National Health Service

(NHS) differs diametrically from the present American system, and contrasts strongly with most of the plans now before Congress. Our summer course explores the historical, cultural, and economic differences which have led the two countries to such different results.

Yet we are also sister countries, resembling one another more than we differ. Both nations are struggling to deliver affordable, publicly acceptable health services. Britain's NHS is not, as caricatured, a bloated bureaucracy

(London continued on page 6)

London (cont.)

indifferent to costs; nor are British subjects apathetic about what they receive. "Managed competition," in fact, intended to increase efficiency, was at the heart of U.K. health care reform in the 1980s. Patient (read consumer) "choice" also figured prominently. Americans can learn from British experience, from its goals, its failures, and its successes. With all this in mind, next summer's program will concentrate on four general issues:

- (1) What is "health care"? What does it mean to think of it as something that can be bought and sold?
- (2) How do we most fairly allocate our resources (money, technology, and people)?
- (3) How have technology and economics changed health care over the past 200 years?
- (4) How does modern urban diversity affect health care?

We make good use of London's resources, by visiting institutes, museums, and clinics, and through our affiliation with the Medical College of St. Bartholomew's Hospital. St. Bart's is located in London's East End, an area of rich ethnic diversity and profound pov-

erty. The impact of socioeconomic status and of culture has turned out to be one of the most practical foci of the course.

I am an anthropologist, with years of experience with the London program; Judy is a philosopher, whose interests in feminist theory should add an important new perspective. The course offers six semester credits for graduate and undergraduate students:

HST 487 -- Seminar in Comparative History (3 cr) and PHL 491 -- Special Topics in Philosophy (3 cr). Medical students can arrange for six credits of FMP 580 -- Special Topics in Family Practice.

The course is fairly rigorous, and no place for "tourist wannabes". On the other hand, having fun is one of our priorities; we are in London, after all.

For more information: The Office of Overseas Study, 108 International Center (353-8920). Judy Andre, the Center for Ethics and Humanities (355-7550). Brian Brown: email is best (19910bxb@msu.edu or brownbri@student.msu.edu). You could also write me at 100 Linton Hall.

Interview with New Center Member Dorothy Vawter

While Howard Brody is on sabbatical we are fortunate to have Professor Dorothy Vawter at the Center to teach, write, and conduct research on various bioethics issues. Professor Vawter has most recently been a research associate at the Center for Biomedical Ethics at the University of Minnesota. There she has been the project director on such topics as the use of human fetal tissue and informed consent for living organ donation as well as conducting research on personal responsibility for health and new ethics in a changing health care environment. She has been published in a wide variety of journals such as the New England Journal of Medicine and the Hastings Center Report. Along with her research and publishing Professor Vawter has taught in the department of philosophy at the University of Minnesota and as a visiting professor at the University of Rochester, University of Florida and University of Arkansas. We at the Center look forward to working with her throughout the coming year and welcome her to Michigan State University.

MHR: Before coming here to the Center you had been a research associate at the University of Minnesota's Center for Biomedical Ethics since 1987. I'd like to begin by asking you what sorts of projects you were working on before you came here to Michigan State.

D.V.: The bulk of my time there I was directing a Center project on the use of human fetal tissue. We spent about a year gathering together all the relevant medical and scientific data about it; we really had to look far and wide to gather that information and get it all in one place. Once we felt we really had a handle on the territory we could then examine the ethical issues surrounding it. I found it very interesting, especially since it touches on so many issues that I was interested in before becoming involved in the project.

MHR: Such as?

D.V.: It really touches on issues regarding research on human subjects and that was something I'd been previously involved with in a number of ways. It definitely gets involved in abortion issues and other issues related to women's reproductive health and rights to privacy. And it also clearly involves issues in transplantation. A large, large spectrum of issues come together in this one subject. It was also exciting in that, ultimately we felt were able to make a substantive contribution to the policy on the national level.

MHR: In what way?

D.V.: I think that we were able to draw attention to how policy proposals in Congress and elsewhere were so focused on what all we need to do to protect the fetus that we were almost completely oblivious to the fact that there was someone else involved in this activity, namely the woman, who really needed similar kinds of policy attention to protect and respect her.

MHR: What did you do to alter this kind of approach?

D.V.: Well, first we published information concerning fetal tissue procurement practices which made it clear that donation poses potential risks to a woman's privacy and well-being. Then we published an article in the Hastings Center Report criticizing a bill going through Congress. If you look at the bill that Clinton eventually signed into law you'll see there are now a number of provisions designed to respect and protect the woman's rights that go way beyond any found in previous policy proposals in this country or abroad.

MHR: I know that one of your areas of interest is examining notions of individual responsibility for health, but since your article in this issue covers that topic I'd like to conclude by asking you about some of the other projects you're working on at the moment.

D.V.: Right now, I'm looking at the whole area of living organ donation and seeing what framework for informed consent is appropriate in that setting. We talk about informed consent in therapeutic interventions and what's involved in getting informed consent to be a research subject, but what is informed consent all about when we're asking someone to be a living organ donor? Often we just sort of reach for the therapeutic model, pull out one of those consent forms and apply it in this setting. But is that a reasonable way to go about it or is there something so different about what you do when you agree to be an organ donor that the traditional informed consent models aren't fully appropriate to accomplish what needs to be done here. Over and over again the transplantation community has flagged this issue as one that needs attention and I and a number of colleagues in Minnesota are now working on it.

MHR: That sounds like it will be a fascinating project. Good luck to you and, once again, welcome to the Center and Michigan State University.

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