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Personal Responsibility in Healthcare for Low Socioeconomic Individuals

Introduction

For eight weeks during the summer of 2013, I participated in a Shepherd Internship at the Cleveland Clinic (CCF) in Cleveland, Ohio. Included in the internship was a weekly visit to a behavioral health clinic. The physician with whom I worked that summer had set up a primary care office within the clinic to allow for better coordination of medical and psychiatric care. I will forever remember one patient in particular. I will call her Jane. Jane was a 55-year-old, ex-IV heroin addict and had been living in a women's shelter for three months. She had a Body Mass Index (BMI) of 36.3 percent (a normal BMI is 19-25 percent) and was a heavy smoker, evident by the five boxes of cigarettes that fell out of her purse during the appointment. When asked about her daily food and drink intake, she described a high-fat, high-carbohydrate, low-fruit and vegetable diet and an excessive soda habit. When asked about her diabetes, she told the physician that she never checked her blood sugar, even though she had all the supplies necessary to do so. She also admitted that she had run out of three of her four heart and blood pressure medications two weeks previous. When the physician inquired as to why she had not requested a refill, Jane responded, "I just never got around to it." By the end of the appointment, Jane had received four referrals – a mammogram, a cardiology appointment, a sleep study and a colonoscopy – and ten prescriptions. These referrals and prescriptions amounted to tens of thousands of dollars worth of medical care, all of which were billed to Medicaid, and therefore, funded by the taxpayer. Upon leaving the examination room, I was confused. It seemed that Jane had just received an enormous amount of support when she, herself, was doing very little to improve her own health. I wondered what responsibility society had to help Jane towards better health and what personal responsibilities Jane had in pursuing better health.

Prescriptions at this behavioral health clinic are four dollars each. One afternoon, the nurse practitioner was called to the lobby to assist the pharmacist with a patient who was requesting that her prescription fee be waived. I will call this patient Mary. Mary told the nurse that she did not have enough money to pay for her medication but that it was imperative she fill the prescription today because she was completely out of the medication. When questioned further, Mary admitted that she had spent forty dollars on cigarettes on her way to the clinic. This money could have been put towards ten prescription refills. Should Mary be given her medication free of charge or is it her personal responsibility to prioritize medication above cigarettes? It is my hope that by the end of this paper, we will have an answer to the questions raised in these anecdotes.

Poverty is a complex and broad issue. The scope of this paper is limited to health and poverty. In particular, I will determine the degree to which low socio-economic status (SES) individuals are personally responsible for their own health, and what role government assistance programs and other supportive institutions play in the process. The philosophy of Norman Daniels and Amartya Sen are central to answering this question. Daniels applies the Rawlsian principle of fair equality of opportunity to healthcare. Sen developed his theory of capabilities and functionings in juxtaposition to Rawls.

Fighting poverty through healthcare is unique to other anti-poverty strategies. First, a person's health is largely determined by personal habit and medical compliance – personal responsibility has a significant influence on these two determinants. Good health requires access to good healthcare. However, it also requires that one use that healthcare and comply with physician recommendations. Second, health is a highly complex and multifaceted state that

depends, not only on traditional medical therapies, but also on social determinants. Social determinants make is more difficult to assign personal responsibility.

Section I: The Special Moral Importance of Health

Following Norman Daniels, I argue that health is of special moral importance because good health is necessary to live a happy and flourishing life. One might ask why having good health is different from having a car. The answer is twofold. First, although health is a matter of degree, a basic level of health is necessary for survival. Second, without health, one does not have the opportunity range for normal functioning (Daniels, 44). Health is a necessary aspect of individual opportunity; this is to say it is a prerequisite to opportunity. Health is not something individuals choose to pursue once opportunity is granted. Individuals lacking a normal opportunity range, defined as, "the array of life plans reasonable persons are likely to develop for themselves," are unable to pursue their personal preferences and aspirations (Daniels, 43). These may include buying a car. In essence, health is of special moral importance because without it, personal preferences are obsolete and one is unable to function in society.

Maslow's Hierarchy of Needs alludes to the special moral importance of health. Developed in 1943, this motivational level pyramid illustrates that, without health, other motivations are futile. The Hierarchy involves five motivational levels.

1. **Biological and Physiological** needs, including food, water, shelter and health.
2. **Safety** needs, including, security and law.
3. **Social** needs, including belongingness and love.
4. **Esteem** needs, including achievement, self-respect and respect from others.
5. **Self-Actualization** needs, including realizing personal potential and self-fulfillment.

If biological needs are not met, an individual is "stuck" on the bottom of the pyramid and unable to ascend. Maslow's Hierarchy of Needs illustrates that individuals do not have the freedom to choose and pursue their desired life goals without good health. It stands in direct support of Daniels' view.

Section II: Norman Daniels on Fair Equality of Opportunity

The fair equality of opportunity principle, first developed by John Rawls in his *Theory of Justice*, states that the social circumstances into which one is born (one's lottery of birth) are determinants of individual opportunity, and not within one's control. The World Health Organization (WHO) divides social determinants of health into 7 categories: 1) income and social status; 2) education; 3) physical environment; 4) social support networks; 5) genetics; 6) health services; 7) gender (WHO). Some health determinants, such as education, stem from a social lottery and can be changed and controlled. Others, such as genes, stem from a natural lottery and are out of our control.

Imagine a horse race. Each horse begins the race at a different time, with some allowed a head start and some forced to wait. Few would argue that this is not a fair race. These differing start times are equivalent to the different social determinants that individuals hold. It seems that, when social determinants determine one's success in life, this too is unfair. Rawls argues that it is society's responsibility to mitigate the social circumstances that act as barriers to advantage so that social determinants may be overcome to the extent possible.

Daniels applies Rawls' principle of fair equality of opportunity to health, claiming that health is, to a large extent, a social circumstance that society can (and must) mitigate, and control. While Rawls focused on education, Daniels focuses on health. The fair equality of

opportunity principle is acceptably extended to health because health is necessary in maintaining a normal opportunity range. Daniels invokes a holistic definition of health that extends far beyond preventative and therapeutic medicine. He places health needs into six categories (Daniels, 42).

1. Adequate nutrition, including caloric intake and a balanced diet
2. Sanitary, safe, unpolluted living and working conditions
3. Exercise, rest, and such important lifestyle features as avoiding substance abuse
4. Preventive, curative, rehabilitative and compensatory personal medical services
5. Nonmedical personal and social support services
6. An appropriate distribution of other social determinants of health

Daniels' holistic definition of health, which I take to be correct, is broader than society's commonly accepted definition.

To see why a holistic definition is preferable, consider the health of HIV positive and AIDS individuals. The U.S. has excellent HIV/AIDS medical assistance programs; all medical and medication costs are fully covered by the government. Patients may even receive co-pay cards so that they do not have to pay that nominal fee. Therefore, access to traditional healthcare is not a problem for HIV/AIDS patients. It is the other categories of health that pose significant problems to their health. One memorable gentleman that I saw while at CCF, I will call him Bill, illustrates these problems well. Bill was very poor and came from a broken family (6). He told me of his apartment, which was infested with bed buds, had lead chipped walls, and cracked ceilings (2). Bill said he could not sleep at night because of the bed bugs, and because he worried that he would hear gunshots outside his window. He was in a constant state of anxiety and paranoia that made it impossible for him to function as a normal member of society.

Furthermore, he lacked a supportive family structure that might have helped him to cope with his anxiety and fear (5). Instead, Bill relied on drugs to ease his worries (3). He lived in a food desert, and consequently, subsisted on a simple carbohydrate and high-fat diet (1). Although Bill's HIV viral load was well controlled, and he was in good physical health, we cannot say that he was in good holistic health; he lacked categories 1, 2, 3, 5 and 6 listed above.

Having described the holistic definition of health, I proceed to Daniels' central argument: social determinants of health are necessary for equality of opportunity.

> The intuition behind fair equality opportunity is to restore the fair opportunity range for individuals to what they would have if social arrangements were more just and less unequal. A similar intuition underlies our practice in protecting opportunity against ill health. The impairment of normal functions by significant pathology, such as serious disease, injury or disability, restricts individuals' opportunity relative to the portion of the normal range that their skills and talents would have made available to them were they healthy. (Daniels, 44-45)

Under this criterion, health is necessary for opportunity, and opportunity is a primary social good. Health is determined largely by both social circumstances, and access to high-quality therapeutic and preventive medicine. Note that other primary goods include basic liberties, employment opportunities, income and wealth, and the social bases of self-respect (Beckley, 110).

It is empirically proven that prosperity is correlated with health. It is also empirically proven that the health gradient is based upon inequality in income, rather than income itself – the steepest gradient is observed in highly unequal populations (Wikler, 114 *in Anand*). Consequently, health is not simply a matter of income. For example, the U.S. and Costa Rica share similar life expectancies. Although the U.S. has greater wealth, it also has more inequality compared to Costa Rica. Since the U.S. is a highly unequal country, and inequality in primary

goods affects health, the health of U.S. citizens is also highly unequal. However, Daniels does not require that health be fully equal among citizens. Rather, employing the difference principle, inequality in healthcare is acceptable (just) to the point that it helps the least well off in society (Daniels, 58). Furthermore, Daniels states that healthcare inequality is unjust when it is "avoidable, unnecessary and unfair" (Daniels, 90). It is easy to determine one's right to healthcare in extreme situations. For example, most would agree that all individuals should have access to primary care, and few would argue that all individuals are entitled to a "nose job." However, determining one's right to healthcare and the extent of that right for "middle ground" health situations – infertility, elective surgery, braces, etc. - are less clear.

A practical discussion of health must acknowledge that, first, we live in a world of limited resources and, second, these limited resources must support other desirable social goods (in addition to health). It must also be noted that healthcare investments may, at times, harm these other social goods, and have opportunity costs on other measures of health. "Investing in health care has opportunity costs even though it helps to promote opportunity" (Daniels, 104). Limited resources, and other social goods necessitate effective and prioritized resource allocation.

Personal responsibility plays into the distribution of healthcare resources and is tied closely to effectiveness. Although I will not delve into this argument yet, I wish to distinguish deservedness from effectiveness. Deservedness is defined as "to be worth, fit, or suitable for some reward or requital" (Merriam-Webster Dictionary). Effectiveness is determined by what policy is most effective in the given situation. Asking about the medical effectiveness of healthcare, both in the sense of medical treatments and altering social determinants, is independent of deservedness.

I fully acknowledge the difficulty of judging personal responsibility in health. However, just because something is difficult, does not mean it can be ignored. Judging personal responsibility is especially difficult with low SES individuals because low income and harmful social determinants are correlated with risky behavior. When considering personal responsibility, society must ensure that low SES individuals are not punished for their lottery of birth in regards to controllable social determinants. Consider an individual who eats an unhealthy diet because she is uneducated about nutrition and lives in a food desert, or an impoverished child who is denied a healthy diet because his mother cannot afford food. Should these individuals be held responsible for their dietary choices? Surely not.

However, with 'middle ground' situations, the answers are less clear. Should Mary, who chose to spend her money on cigarettes rather than medication, receive her medication for free? Social determinants related to culture, tobacco company influence, inaccessibility to smoking programs and lack of education, are relevant to this question. Should an individual living a high-risk lifestyle and suffering from bad health as a result, receive equivalent healthcare resources compared to an individual living a low-risk lifestyle who also suffers from bad health for other reasons? Personal responsibility may be a relevant distinction here. Should healthcare resource allocations be based on previous irresponsibility if, currently, the individual is ready to act responsibly and comply with the recommended health program? These are complex questions that require further analysis of social determinants, personal habits, personal responsibility, resource allocation, and policy effectiveness, and will provide a central driving force for this paper.

Section III: Amartya Sen on Capabilities and Opportunities

Sen writes extensively on individual capabilities, opportunities and functionings and focuses on the abilities and opportunities necessary for wellbeing. "The quality of persons' lives is contingent on what they are able to achieve, and a life well lived is one in which individuals sustain and exercise a group of core capabilities" (Beauchamp et al., 259). Capabilities are defined as what an individual can do or become. Functionings are defined as "various things that [a person] manages to do or be in life." Functionings range from proper nutrition to self-respect. Under Daniels' view, primary goods are necessary to achieve one's goals, and therefore, necessary for justice. Sen expands upon this claim, arguing that primary goods are necessary but insufficient because they do not give all individuals the capabilities to achieve their goals. Consider a kidney dialysis patient. An individual in need of kidney dialysis who has all of the same basic liberties, access to positions, and income and wealth as a healthy individual will have fewer opportunities (Sen *1992*, 107). Sen replaces primary goods with capabilities. Capabilities give rise to "alternative combinations of functionings" from which individuals can choose. Capability determines neither what functionings an individual chooses to pursue nor his actual achievement of those functionings. It only dictates that he has the *ability* to choose and develop his functionings (Beckley, 110). As such, equality is measured by freedom.

Sen's equal capability view finds accord with Daniels' normal functioning view. For Sen, the distribution of capabilities determines justice and capabilities are a positive freedom. "People have achieved equality when they have equality in positive freedom, that is, when their capability sets are equal" (Daniels, 66). Applying this idea to health, individuals in poor health have less positive freedom, which is unjust (Daniels, 64). Capabilities, like primary goods need

not be equal among all individuals (Sen *1993*, 31). Rather it must be the case that no single capability set is significantly worse than another (Daniels, 69).

Harlan Beckley states that even if absolute equality of capability existed between all individuals, it would not produce the same functionings among individuals. Even if all capabilities are equal, some individuals will be more successful than others. This is because individuals do not use their capabilities equally. This distinction suggests that individuals are responsible for developing their capabilities into actual functionings. It also suggests that some individuals waste their capabilities, while others maximize their capabilities to their greatest benefit (Beckley, 113). This is Sen's distinction between opportunity as freedom and opportunity as achievement. Furthermore, different individuals may prioritize different functionings and pursue different goals.

Section IV: Education and Mental Health in the Holistic Approach to Health

With this understanding of Daniels' fair equality of opportunity principles, and Sen's capabilities and functionings theory, we can consider the holistic definition of health in greater detail.

Education, Behavior, and Health

Education and health share a correlated and parallel relationship. First, both are vital components of fair equality of opportunity. Second, the distribution of both education and health are severely unequal in the U.S. Third, education and health hold a causal relationship; education is vital in the promotion of health. The fair equality of opportunity principle requires that low SES individuals receive greater educational opportunities to 'make-up' for the harms of social determinants. The government holds the responsibility to educate its citizens.

Educated people engage in fewer risky behaviors. First, Jha et al. (2006) found that for low SES populations, smoking contributes to half of male mortality. Whether or not this is an irresponsible behavior or a socially determined behavior will differ with the individual. The correlation is present regardless. Second, education is also correlated with healthy eating, and healthy eating is correlated with health. Everyone eats a pizza or a hamburger from time to time. However, what separates Individual A from Individual B is that A knows that eating pizza is unhealthy while B is ignorant of the information. Furthermore, these individuals may differ in their personal habits. Information to overcome nutrition naiveté is one thing, but support in forming healthy eating habits is another. More the information is required to form good habits. Individuals can only be expected to eat healthy if they know what is healthy to eat, are supported in their pursuit of healthy eating, and have access to healthy foods.

Mental Health, Self-Efficacy, Behavior, and Health

Mental health is an influential social determinant, and is arguably the largest contributing factor to personal behavior. Understanding the causal links between mental health, behavior, and health is highly relevant when assigning personal responsibility. In his Social Learning Theory, Albert Bandura claims that behavior change and maintenance are a function of (1) outcome expectations for a particular behavior, and (2) the efficacy expectations one holds in one's ability to act in that way. Both expectations involve an individual's *belief* about his capabilities rather than the fact of his *actual* capabilities.

Efficacy expectations vary in magnitude, strength and generality. Magnitude refers to the difficulty of the task – high-magnitude expectations mean that persons feel confident in their ability to perform difficult tasks. Strength is based on the probability judgment of the likelihood

of performing the task successfully. Generality refers to how applicable efficacy expectations are to the situation (Stretcher, 74). One's self-efficacy expectations influence existing behaviors, the acquisition of new behaviors, and the inhibition or disinhibition of behaviors. Self-efficacy also controls the effort and time individuals devote to a task. Consequently, self-efficacy is a vital component of health education and helps to initiate and maintain behavior changes (Stretcher, 74).

Efficacy expectations are acquired from four sources; personal accomplishment, vicarious experiences (learning from others), verbal persuasion, and physiological state (Stretcher, 76). One's appraisal of this information, including weight and interpretation, determine perceived efficacy. Individuals tend to dwell on certain facts (be they positive or negative), while turning a blind eye to others. Individuals with low self-efficacy give little weight to positive efficacy information, and instead fixate on negative information. As such, they tend to believe a task is unachievable, when in actuality, they likely have the capabilities to do so. Furthermore, individuals with a high level of self-efficacy are able to handle occasional setbacks, while those with low self-efficacy are negatively affected by their failures. Efficacy is a capability. Self-efficacy should be viewed as both, something for which one is responsible (personal accomplishment) and something that is fostered and nurtured by society and other individuals (vicarious experiences and verbal persuasion). Physiological states should be seen as a condition largely determined by the social determinants, people, and events in one's life, as well as a condition over which the individual has control, to a certain extent. Many poor individuals have psychological barriers to functionings that are often due to circumstances beyond the control of the responsible person. Distinguishing between these different parts is extremely difficult to do.

Countless studies conclude that self-efficacy is vital for initiating and maintaining behavioral changes. This correlation proves that behavior is a product of perceived capabilities (Stretcher, 87). Prochaska et al. found that self-efficacy scores were positively associated with successful progress through the stages of smoking sensation. Brod and Hall found that smoking program participants had higher self-efficacy scores compared to those of non-participants. Chambliss et al. found that self-efficacy scores were positively associated with successful weight loss. Ewart et al. found that self-efficacy scores were positively associated with exercise, and in turn, exercise predicted self-efficacy scores. This same study found that mental health counseling increased self-efficacy scores. For example, an individual will likely have low self-efficacy if they are depressed, frequently ill and unemployed. However, once resources are provided to these people, it seems reasonable to expect these individuals to "pull themselves up by their bootstraps" and give themselves the self-respect they deserve. Although some individuals may never be able to accomplish this, others will make these positive strides.

Two aspects of mental health – stress and the basis of self-respect –illustrate the importance of a holistic definition of health. Stress is an uncommon but real health consideration. Stress induces irrational judgments that lead to bad choices and declining personal health. Many of the patients at CCF were noncompliant with doctor recommendations because they were living under debilitating stress. The importance of stress management in promoting health cannot be understated. However, stress cannot be managed solely by traditional health therapies. Often, other holistic factors, such as childcare, housing, an abusive spouse, paying rent, etc. are the greatest sources of stress. Furthermore, although stress is not part of the definition of self-efficacy, efficacy expectations and personal behavior are closely correlated

with stress. Individuals who believe that they are unable to perform a task will find the thought and action of that task stressful. This suggests that self-efficacy is itself capability nurtured by social determinants, as well as something for which persons are responsible. Therefore, we cannot hold individuals personally responsible for their self-efficacy.

Self-respect is another uncommon health consideration and the Rawlsian principle of justice as fairness includes it among the social determinants of health (Daniels, 97). Neither society nor the individual provides self-respect. Rather, the "social basis" of self-respect is what is provided, with society acting as the benefactor. With this basis, the individual can respect herself and others. The basis for self-respect is vital for active participation in society and its absence constitutes a relative deprivation. Social determinants heavily influence an individual's ability to respect herself. For example, if one is homeless or uneducated, she may feel inferior to those around her who have stable housing and are well educated.

Self-efficacy and self-respect are distinct, but closely related, concepts. Self-respect is a function of self-worth, while self-efficacy is a function of capability beliefs (Stretcher, 77). Both self-respect and self-efficacy are necessary components of personal responsibility. If one or both of these characteristics is absent, personal responsibility may be hard to demand. An individual who respects herself is more likely to take care of herself, given other capabilities to do so. An individual with high self-efficacy will believe that she can promote positive changes in her own health. The basis for self-respect and self-efficacy are necessary components for individuals to have fair and equal opportunity to succeed. Self-respect provides an individual with a purpose in life – she understands that she is worth something as a person. In turn, this self-worth provides motivation to the individual towards achieving her goal of good health. Lastly, believing in one's self (because of high self-efficacy) is a necessary tool in the pursuit of this goal.

Section V: Personal Responsibility, Self-Efficacy and the Distribution of Healthcare

Personal responsibility's role in health has been discussed for centuries, beginning with Galen in 180 A.D. While its prominence in healthcare policy has increased in the last twenty-five years, a demand for personal responsibility is rare in current public health policy (Wikler, 110 *in Anand*). I argue that personal responsibility should hold a peripheral role in healthcare distribution. By 'peripheral' personal responsibility, I mean that the allocation of healthcare resources is a function of treatment effectiveness and patient compliance, but that personal responsibility is intrinsic within these factors. Effectiveness is a judgment call made by a reasonable physician. To continue or discontinue treatment should always involve an aggregate of physician opinions. 'Treatment,' as defined in this capstone, is a holistic approach to health, as defined by Daniels.[1] There is no denying that those who take good care of themselves are healthier than those who fail to do so; the individual is the most important factor of personal health. Regardless of the amount of money, support, time, and compassion given to the individual, if the individual fails to take action in applying these benefits towards good health, nothing good will come of them. Personal responsibility and action are necessary for effective medical treatment.

Since this policy relies on the holistic healthcare model to account for social determinants and support behavior change, it assumes that the necessary components of this model are present. Society has a responsibility to provide these components. Once the support structure and resources are present, the ball is largely in the individuals "court." It is necessary that she use the tools and resources available to her to pursue good health. This policy puts the pressure on the patient and, at the same time, gives the patient the skills to excel. Asking an individual to act proactively is required for treatment efficacy, and in most cases, it is a reasonable expectation. Judgments can themselves engender capability to take responsibility if exercised judiciously.

[1] See Daniels' definition of holistic health on page 5.

Note that, in reality, access to every needed resource is unlikely. Instead, access will tend to be a matter of degree that society should strive to maximize.

Some individuals will never be able to change their behavior and adopt the personal responsibility needed to promote their own health. Some individuals subsist in such severely disadvantaged lives that they will never be 'ready' to change their situation. Society should not blame these individuals for their inability to change, and we do not conclude that medical care for these individuals is undeserved. Rather, we may conclude that continued medical care is futile.[2] Ultimately, judgments on treatment effectiveness determine healthcare resource allocation. An individual's personal responsible does not factor into the actual judgment. Instead, it promotes efficacy because a personally responsible individual will likely have a successful treatment program.

I argue that all patients ought to receive healthcare initially. This care is provided regardless of probabilistic outcome and regardless of whether or not an individual's health is due to circumstances within, or outside of, her control. Treatment effectiveness and peripheral personal responsibility begin to play a role following the initial provision of care. If the patient is compliant and the treatment is effective, then the treatment will continue. However, if the patient is noncompliant and the treatment is ineffective, certain healthcare resources may be discontinued. This does not mean that all aspects of healthcare ought to be withheld. Instead, the components of treatment shown to be ineffective should be discontinued. For example, an alcoholic who continues to drink ought not receive a kidney transplant but ought to receive palliative care. Furthermore, he is still owed supportive resources that promote behavior change. It might be the case that patients are, at present, 'unready' to act responsibly, but that at some point in the future, they could reach a 'ready' state. A policy based on effectiveness assigns

[2] See the distinction between deservedness and effectiveness on page 7.

incentives for behavior change. Incentives in healthcare are a highly effective strategy for behavior change because they reward individuals for good behavior (Sen 2000 in Beckley, 117). Under my proposed policy, receiving continued healthcare resources is the incentive for changing one's behavior, and complying with physician recommendation.

If we accept effectiveness as a fair and realistic criterion for the allocation of healthcare resources, then we must decide the degree to which heath improvement and/or patient compliance warrants continued treatment, and the initial length of time that the treatment should be given to work. This, I contend, is a difficult endeavor for many reasons and lacks a single bright line. Treatment outcomes vary widely among individuals and illnesses. Even when two individuals are given the same care and take the same steps to improve their health, outcomes for the severely ill patient are likely to be worse compared to outcomes for the less ill patient. Policy should not punish an individual for this reality. Furthermore, some illnesses can only be managed, never cured. An individual with type-one diabetes will never be cured of the illness no matter her diligence in managing the disease.

Determining the initial treatment time duration is too difficult to judge and ought to vary with the situation. Providing exact time limits requires extensive research and falls outside the scope of this capstone. However, I will say that the time interval must be sufficiently long. Changes in behavior do not occur "overnight," especially when poor mental health contributes to poor behavior. Furthermore, changes in behavior are unlikely to occur before individuals find themselves a stable and safe environment in which to live. Establishing stable housing and support systems too takes time. Because resources are allocated based on effectiveness, we must ensure that we do not punish low SES individuals for the desperate life situation in which

they start treatment. Doing so would be unjust. Society owes all individuals a fair and equal opportunity for an effective treatment plan and good health.

Although Rawls does not address healthcare specifically, my policy is in line with his fair equality of opportunity principle. Rawls holds individuals responsible for maximizing their just share of social goods and capabilities. Personal preferences are one's own responsibility and, as such, one's priorities are not society's responsibility (Wikler, 120 *in Anand*). If an individual is given access to holistic healthcare and the necessary resources for behavioral change, and he does not comply with physician recommendations, there is nothing left for society to do. The patient is failing to employ his resources. Providing further treatment would be ineffective. Again, I do not claim that the patient is acting irresponsibly and is undeserving of healthcare. Some patients will never be able to change their behavior and neither society nor the individual can do anything to change the situation. While we always think this is lamentable, society would be misallocating its limited and valuable resources by continuing to invest in these individuals. Resources would be better spent on other individuals who can (and will) apply them towards positive health changes. Denying these latter individuals the resources in preference for the noncompliant patient is unjust.[3]

The discussion to this point has been in the context of chronic care. However, this policy is equally applicable to prospective medical care. Consider a joint replacement surgery. Although obesity significantly reduces the lifespan of an artificial joint, current policy does not require that patients be of a healthy weight prior to surgery. Consequently, each year, thousands of joint replacements wear out far sooner than is necessary, which is ineffective and expensive. The cost-benefit ratios and long-term health of patients would be much improved if obese

[3] I do maintain my earlier qualification that we should be open to reinstating care if the individual does show changed behavior and thus effectiveness.

individuals were refused joint replacements. With the limited resources available to society and the significant cost of a joint replacement, society ought to treat individuals only when the treatment is likely to be effective. Treating individuals when treatment is likely to fail harms other individuals who may not receive a surgery because there are not enough resources to treat everyone. Obese patients would be provided the resources, support systems, and education necessary to change behavior, and the prospect of surgery would serve as an incentive (assuming persons are capable or responding to incentives). If patients apply the resources to change their behavior, they would receive the joint replacement. However, if they did not do so, they would not receive the procedure. If the patient is unable to change her behavior, she lacks capability. If the patient is able to change her behavior, but does not, she may be irresponsible. In either case, denial of treatment is based solely on ineffectiveness, not on personal responsibility.

In cases of emergency care, treatment must always be provided. An individual experiencing a heart attack due to his high-fat diet should be given immediate care. An individual suffering from a violent hypoglycemic attack because she fails to control her diabetes should be given immediate care. In these cases, treatment is a life or death matter. Although the policy I propose is not directly applicable to emergency care, since there is no time duration component, it is also not in contradiction because treatment will likely be effective. Providing care keeps the patient alive so that she may have the opportunity to change her behavior. Furthermore, care can be accompanied by a rather harsh "reality check" about the health consequences should she fail to change her behavior. This judgment is motivation for change.

As stated earlier, personal responsibility is a periphery component, as opposed to a driving force, of healthcare policy. Efficacy is the ultimate criterion for resource allocation. Therefore, determining whether to continue or withhold care does not require an evaluation of

personal responsibility; it only demands an evaluation of effectiveness. Efficacy is a measurable, central aspect of healthcare, and therefore, a reasonable criterion. Personal responsibility is included only insofar as a person who is responsible will likely have an effective treatment; personal responsibility largely determines patient behavior and patient behavior is a determinant of treatment effectiveness. Personal responsibility holds an influential *indirect* influence but is ultimately irrelevant (in the *direct* sense) to the decision to continue or withhold care. Implementation of personal responsibility in this way is preferable for many reasons.

First, peripheral personal responsibility removes the need to determine if poor health is due to uncontrollable social determinants, or factors within one's control. Deciphering between controllable and uncontrollable factors is nearly impossible. Although physicians are good judges of character, they cannot realistically be expected to understand every intimate detail of a patients' life, both past and present. However, since social determinants are the accumulation of life events, such evaluation would be necessary to accurately evaluate personal responsibility. Furthermore, these judgments are highly subjective. Treatment effectiveness, on the other hand, relies on measurable factor, i.e. test results, compliance percentages, time, etc. These are objective factors that physicians are trained to understand and contextualize.

Second, peripheral personal responsibility removes the worry of arbitrary faultfinding (Wikler, 128 *in Anand*). Wikler explains that risky behaviors do not receive equal condemnation. For example, lack of exercise and unhealthy eating are seen as sinful activities while injury from extreme sports is seen as heroic. "If the moral principle underlying a move to give greater prominence to personal responsibility for health is that those who generate costs should pay for them, we should not expect that the only ones made to shoulder the costs are those who behave in ways that offend their neighbors" (Wikler, 129 *in Anand).* Effectiveness

does not require a risk-value assessment. It only requires an outcomes assessment. Furthermore, removing a risk evaluation avoids the unfortunate trend that low SES individuals are often blamed for their risky behavior while well-off individuals are given a "free pass." Wealthy people smoke, eat McDonalds Big Macs, fail to check their blood sugar, etc. However, they are criticized far less for their rash actions than are low SES individuals.

Third, peripheral responsibility removes the worry that physicians must act in unsympathetic manners. All patients are shown dignity and respect when provided with initial treatment, regardless of risky behavior. If treatment is withheld, it is not because the continued allocation of limited and valuable healthcare resources is judged to be ineffective in helping the patient, and harmful to others in society. Therefore, withholding treatment is not unsympathetic. Instead it is a cost-benefit decision that targets and maximizes equal opportunity.

Fourth, an indirect inclusion of personal responsibility in healthcare respects free choice in personal development and pursuit of happiness.

> Interpersonal variation in goals, preferences, and tastes – beyond the reckoning of the most omniscient managers – requires individual liberty so that circumstances can be tailored to the individual…Choosing freely tells others that one is the kind of being capable of doing so, and this is a prerequisite to participation as a person in a society of free and equal beings…[Personal responsibility] can be part of a program of 'positive freedom' or 'empowerment' a realization that actions taken can have a marked and positive impact on one's health, with radiating good effects on other dimensions of life and on other people." (Wikler, 128 *in Anand*)

Sen states that capabilities are a positive freedom. Therefore, society must allow individuals to use this freedom; doing so provides empowerment. Indirectly including personal responsibility in healthcare empowers and motivates individuals, proving to them that they are a powerful component of their own health. In turn, positive health improvements serve to further increase self-efficacy and self-respect, and can have resonating positive consequences in other aspects of the individual's life.

Having shown that a peripheral use of personal responsibility is advantageous to promote public health, I now wish to discuss reasons that support my overall policy.

I. First, it insists on compliance. This is both effective for the patient and potentially beneficial to others in society. HIV and AIDS treatment provides an excellent example of the need for compliance in healthcare, and the detriment to one's self, and to others, when non-compliant. When an HIV/AIDS patient fails to take her medications, her viral loads increase and the individual becomes ill. Furthermore, her noncompliance leads to drug resistance. When the HIV virus acquires resistance to a particular drug, that drug can no longer be used to treat the disease. Therefore, one individual's noncompliance affects all HIV/AIDS patients.

II. Second, the holistic healthcare approach provides individuals with the opportunity to change their behavior when given the capabilities to do so. This opportunity, in turn, increases the likelihood that treatments will be effective, and care can continue. Some may argue that this policy is unfair to low SES groups – I disagree. There is nothing unfair about allocating resources to an individual with the expectation that those resources are utilized in beneficial ways. The same expectation ought to be held of well-off individuals. Society owes all individuals the capabilities to achieve their basic functionings. However, if individuals fail to take advantage of those opportunities, either because they have incorrect priorities, or because they are simply too disadvantaged to be able to do so, resources should no longer be allocated to them. Doing so is ineffective. Withholding care is not a punishment and persons are not to blame for their inability to act responsibly. Instead, withholding care is necessary because we live in a world of limited resources. Yes, the decision to withhold care is harsh; however, hard

choices are necessary in the real world. My recommendation gives all individuals a fair chance at success.

III. Third, a criterion for resource allocation based on effectiveness overlooks previous behavior. The only consideration is whether or not people are taking initiative to change their situation now. People who were previously irresponsible but are now prepared to be responsible are rewarded for their self-motivation and responsibility. In the field of liver transplants, surgeons almost unanimously hold the view that patients should not be denied a transplant due to a history of alcoholism. This is desirable for low SES individuals in particular, because behaviors are often the result of social determinants. However, if physicians can predict with reasonable certainty that a patient will continue to drink following a transplant, that patient should not receive a transplant because drinking would ruin the liver.

A policy that bases resource allocation on effectiveness demands coordinated care. Case managers are an excellent way to ensure coordinated care, and I argue that they should become normal members of a treatment team. Case managers hold a diverse range of responsibilities that seek to supervise patient treatment in a holistic manner. They ensure that patients have their required medication; they drive patients to appointments; they remind patients of appointments; they promote communication between the members of a patient's treatment team; they make house-calls to ensure that the patients is living in a stable environment, etc.

Case managers interact with clients on a one-to-one basis to develop close, and honest relationships. Therefore, they hold a unique perspective of their clients' lives; a perspective that physicians cannot reasonably be expected to know. This perspective serves three salient functions. First, case managers are accurate judges of patient compliance and treatment

effectiveness. While physicians are indeed good judges of character, they have neither the time, nor the information, to evaluate the detailed social determinants of every patient they treat. Case managers, on the other hand, have a holistic understanding of their clients. Based on this understanding, managers can decide what resources and aid should be provided to ensure their patients have fair equality of opportunity to reach good health. This removes the worry that a low SES individual might "fall through the cracks," and be left on his own.

Second, owing to the close relationship between the case manager and client, and the unique insight these managers have, case managers can provide a support network that is often absent from the patient's life. This would likely have noticeable results on a patient's mental stability.

Third, case managers are in the ideal position to nurture and promote personal responsibility. Managers can work with the patient to analyze current behavior and devise useful strategies that promote behavior change. They can act as a nurturing confidant in some situations and a giver of "tough love" in others. Sometimes a "wake-up call" may be exactly what a patient needs in order to change her behavior. In these ways, the case manager nurtures responsibility and provides support that goes beyond mere information while, at the same time, giving the patient ultimate responsibility over her own health.

It is empirically proven that case managers change patient behavior, and increase patient compliance and health. The behavioral health clinic in Cleveland had a small pool of case managers that were allocated to the most high-risk patients. Significant changes in treatment effectiveness and compliance were observed when patients worked with a case manager. They stopped missing appointments and running out of medications. The average "no-show" rate for

patients without case manager is 40 percent. The average "no-show" rate for patients with case managers is 5 percent.

Section VI: Policy in Context

I need to contextualize this proposed policy.

Obesity and nutrition: Society has many responsibilities related to obesity and nutrition, ranging from education on proper nutrition, to ensuring that individuals have the money – through food stamps, food banks, or by some other means – to afford healthy food. Society must work with communities to remove food deserts from the inner city and provide mental health support to patients so that they learn to take care of their nutritional health. If society falls short of these duties, fair equality of opportunity is not realized. However, once the resources are in place, society cannot force someone to eat a healthy diet and exercise regularly. The individual is the only agent able to do so. Therefore, once an individual possesses nutrition information, has access to healthy food and an adequate kitchen (in a stable home), and is given mental health support, it is up to them to adopt healthy practices. Through holistic care and nurturing, we hope to promote personal responsibility necessary for these changes in behavior.

Consider two different examples. The first example pertains to a men's shelter in Cleveland. The men at the shelter were served high-fat, high-carbohydrate, high-sodium, low-vegetable meals. A breakfast consisted of a processed pastry, juice and hotdogs from the night before. As this food was the sole food source, these men were in no way responsible for their unhealthy eating. Here, society had failed to provide them with a fair opportunity to pursue their desired functioning of healthy eating.

The second example pertains to a nutrition program at a community center in Cleveland. Community members could sign up for the free program, which included nutrition classes, exercise classes, health assessments and counseling. This program was an ideal holistic approach to weight loss and healthy eating and the individuals in the program had all the resources necessary to succeed. As a result, the program was highly successful. If individuals did not show improvements in the program, it seems that there is nothing left for society to do. In these cases, the patient should be removed from the program to allow another individual to take advantage of the opportunity. Participation was limited and there was a long waiting list. Allowing one individual to continue to use the program's resources ineffectively, while another is denied them from the beginning is unjust. All individuals ought to be given a fair chance to benefit from the program.

HIV/AIDS treatment: While in Cleveland, I saw countless patients who had discontinued their HIV drug regiment, not because they did not have the medication, but because of some other socially determined harm. Bill, the individual living in a bedbug-infested apartment, stopped taking his medication after his brother tried to kill him. As a consequence, his HIV viral loads were exceedingly high. However, this was not a man who had given up on life. He was smart, personable, and had many aspirations. Were Bill to have safe housing, access to counseling services, and a stable support network, I am confident that he would take his medication. However, because society had failed to provide Bill with fair equality of opportunity, he will likely suffer an early death, which is unjust. While Bill provided a reason for discontinuing his drug regiment, many other patients with whom I spoke could provide no reason for their decision. When asked why they had stopped taking the medications, a common response was, "I

don't know." These individuals were clearly suffering from mental illness, and needed counseling. Access to a case manager would have been immensely beneficial for their health.

HIV/AIDS shows that a strong support system is extremely helpful in promoting patient health. One morning, a patient came into CCF claiming that she wanted to stop her drug regiments because voices in her head told her that the medication would give her AIDS. However, she said that she was not going to stop taking the medication because her daughters were relying on her. This woman was blessed with a loving and supportive family, especially her two daughters. Her daughters served as more than a support network. Her love for them gave her a reason to live, and this sense of self-worth provided motivation for her to take responsibility for her own health.

Scenario 1: Let us reconsider Jane's case. What do we know for certain? We know that she is receiving many traditional healthcare resources, and we know that she is not applying these resources towards good health. However, we do not know why she is acting in this way. Yes, she has a hard life, but is her life so hard that changes in behavior are impossible? Yes, she has a high BMI, but does she have access to healthy food at the women's shelter? Yes, she fails to manage her diabetes, but is this failure due to debilitating stress? We take her actions to be irrational but she may be unable to realize the cause-effect relationship we take to be blatantly clear. Jane has a "tough broad" façade, but she is likely self-conscious and suffers from low self-esteem. A lack of self-respect and low self-efficacy mean that she is not motivated to promote her own health. Furthermore, she lacks a support network that might serve as a safety net for her insecurities. Essentially, many of Jane's social determinants are unknown and, as such, it is

difficult to say if her noncompliance is due to lack of caring or inability to change. Notice the difficulty in judging personal responsibility.

While responsibility is hard to determine, effectiveness of treatment is not. Allocating Jane with expensive healthcare resources has proved wholly ineffective. Therefore, treatment should not continue at its current level. This is not to say that society ought to abandon Jane and leave her to deal with her health on her own. Instead, her physicians should analyze the current treatment strategy to determine what components are ineffective. I have identified three aspects of treatment that require augmentation, but there may certainly be others. First, since she is noncompliant with her heart medications, she should be removed from the heart transplant list; providing Jane with a heart would be ineffective and the heart should be saved for someone who will put it to good use. Second, since she consistently fails to check her blood sugar, provision of these supplies should be discontinued. Third, since she eats an unhealthy diet, and history tells us that this behavior is unlikely to change, expensive cardiology appointments should not be part of her treatment.

I wholly acknowledge that these are harsh recommendations. However, sadly discontinuing these treatments is likely to have little to no negative effect on her health because they are currently having no beneficial effect. At some point in the future, Jane may be ready to change her behavior. At this point, assuming she is wholly invested in her health, resources should be returned to her. This will clearly be a judgment call, but it is a reasonable judgment to make. I sincerely believe that physicians are good judges of character. They can see through a patient's façade to judge her real intentions. No, this is not a foolproof policy, but people's behavior is not black and white. Therefore, policies that deal with people cannot be foolproof. It

is the best option available, and assuming that adequate care and compassion are applied to each patient, physician judgments are likely to be correct.

Scenario 2: Now let us revisit Mary's situation. Mary asked to receive her medication for free because she spent her money on cigarettes. Mary had consistently ignored requests to participate in a free Smoking Cessation program even though she was offered transportation to the class as well. This is a case where the patient fails to take advantage of resources even when the barriers to these opportunities are removed. I conclude that Mary should be given the medication today but that she should be required to pay the reasonable price of four dollars the next time she comes to the clinic. Furthermore, it should be clear that this loan would not be offered again. Were Mary to receive medication for free and without any type of warning, she would learn nothing from the experience, and she would likely repeat the offense. Providing the medication with an "I Owe You" allows her to have the medication she medically requires but, at the same time, gives her a harsh reality check. Asking this reasonable request is a teaching moment that will incentivize her to prioritize buying her medication above buying cigarettes in the future. In this situation, my recommendation is not the one that was taken. Instead the nurse told Mary that she must pay for the medication because it is a matter of priority. Mary said she would have to wait until her next Welfare check came in, at which point the nurse asked her if she would wait until that check came in to buy more cigarettes. Mary curtly replied, "no."

Conclusion

Health is the accumulation of the past and a hard life manifests itself in poor health. The link between poverty and health is a highly complex issue and there is no silver bullet to

address the problem. However there are healthcare strategies which will support individuals with igood health. These strategies must employ a holistic definition of health and address the harmful social determinants that drive individuals into poverty and ensure that they stay there. I argue that personal responsibility plays a peripheral role in the allocation of healthcare resources in that it promotes effective healthcare treatments. Under my proposed policy, all individuals receive healthcare initially. Following a sufficient time period in which the treatment is allowed to work, a judgment is made as to whether the treatment has been effective. If the treatment is judged to be effective, then it will continue to be provided. If the treatment is judged to be ineffective, then certain aspects of the treatment plan will be discontinued. If the patient cannot apply the resources he is given towards good health, then society cannot justify continuing to provide him with such aid. Those resources should be allocated towards an individual who can benefit from them. Providing or withholding treatment is based on efficacy alone and the patient is not blamed for her inability to change her behavior and act responsibly. When treatment is withheld, it is not because the patient is undeserving of such aid. Rather, it is the sad reality of the situation that he is unable to use his resources, and therefore they must be given to someone else. Even if certain aspects of healthcare are withheld, those individuals ought to still receive support and nurturing so that at some point in the future, they may be ready to adopt personal responsibility and, in turn, promote a healthy lifestyle for themselves.

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