

UNHEALTHY HEALTH CARE BEHAVIOUR: WHOSE RESPONSIBILITY?

S Kling

Associate Professor, Department of Paediatrics and Child Health, Stellenbosch University and Tygerberg Children's Hospital
Email | sk@sun.ac.za

INTRODUCTION

The issue of people taking responsibility for their health and what to do if they do not, frequently arises during consultations between patients and health care professionals. Whose responsibility is it to ensure that the asthmatic uses her controller medication even when she feels well? Who is responsible when the person who has previously had an anaphylactic reaction does not use his injectable adrenaline as advised?

Consider the following scenarios:

- Mrs X is an alcoholic and goes into liver failure. Should she be considered for a liver transplant?
- Mr D has been a heavy smoker all his life, and develops ischaemic heart disease, requiring coronary bypass surgery. Should he be granted this surgery? Should any pre-conditions be stipulated, e.g. that he has to stop smoking if he undergoes surgery? Should he pay more for this operation than, say a non-smoker?
- Ms N is obese and has diabetes. Should she receive the same health care benefits from the funder as Ms A who is not overweight and has diabetes?

THE SOUTH AFRICAN DISEASE BURDEN

South Africa has been described as having a quadruple burden of disease: the HIV/AIDS pandemic; violence and other injuries; infectious diseases other than AIDS; and non-communicable diseases (NCDs).¹

NCDs are chronic medical conditions or diseases which are non-infectious. The major NCDs in South Africa are cardiovascular diseases, diabetes, cancer, chronic respiratory diseases (such as asthma) and mental illness.² Unhealthy health care behaviours frequently precipitate the NCDs, which result when they are combined with metabolic risk factors. The risk factors associated with NCDs are overweight and obesity, hypertension, increased blood glucose levels and high blood cholesterol levels (particularly raised LDL cholesterol). Most of these risk factors are considered modifiable through changes in behaviours, such as eating a healthy diet, taking regular physical activity, not smoking, and avoiding excessive alcohol intake.

Considering the analogy of asthma, the costs of non-adherence to therapy are considerable, and run into

hundreds of billions of dollars annually in the United States of America.³ This includes wasted consultations and medication, and the direct and indirect costs resulting from asthma exacerbations. Non-adherence research has identified multiple causes that need to be addressed, and that this does not only involve the patient and the health care provider.³ The question, however, is whether individuals should be held responsible for their health care choices, and whether this should be a moral as well as an economic responsibility. This is controversial and evokes heated debate among the public as well as health care funders and the state. It speaks to the distribution of resources in health care, and who should pay for them (i.e. distributive justice).

In South Africa, the National Patients' Rights Charter includes responsibilities; the first of these is "to take care of his or her health."⁴ There is however no stipulation that if this does not happen, the patient will be denied health care. Private health care funders in South Africa advertise incentives for members to practise healthy living, but again there are no penalties for not adhering to this. Some countries, however, have written responsibility for health into their policies and medical aid plans by stipulating co-payments and regulating claims for certain types of health care.⁵

Do these stipulations and incentives infringe people's autonomy and personal freedom? To what extent can we hold people responsible for diseases that result from actions that affect their health, and can we deny them expensive treatment if this is the case? And, to what extent can we impose requirements for certain lifestyle changes (e.g. weight loss or smoking cessation) before a patient is admitted for a routine surgical procedure?⁵

In the next sections I will look at some of the arguments for and against holding individual people responsible for health care.

ARGUMENTS FOR INDIVIDUAL RESPONSIBILITY IN HEALTH CARE

Cappelen divides these arguments into "backwards looking" and "forward looking" or consequentialist.⁶ The "backwards looking" argument states that the "distribution of burdens and benefits should be linked to how different individuals contributed to the creation of these burdens

and benefits". This implies that it may be morally pertinent to assess the extent to which the individual contributed to the need and therefore the cost of treatment. Proponents of individuals being held responsible for health care costs if they engage in unhealthy or risky behaviour argue that it is unfair to impose the costs of health care of these patients on those people who have avoided disease by following healthy habits.⁶ As an example, a person who chooses to continue to smoke despite understanding the risks, could be held responsible in the event of developing lung cancer. Similarly, removal of a tattoo would not be paid for by a public health institution, whereas surgery for a disfiguring nevus would be covered.⁶

The "forward looking" argument proposes that negative and positive incentives should be employed to encourage healthy behaviour.⁶ An example of a negative incentive would be the taxes levied on cigarettes and tobacco and alcohol. Positive incentives would include free screening or vaccination in the event of good health behaviours. According to this argument, holding individuals responsible for their health care choices is seen as a means to an end and not an end in itself.⁶ This is the basis of utilitarian arguments in the distribution of health resources, especially where measures such as quality adjusted life years (QALYs) are used.

ARGUMENTS AGAINST INDIVIDUAL RESPONSIBILITY IN HEALTH CARE

Cappelen distinguishes between "normative" and "practical" arguments invoked against individual responsibility being an important consideration in allocation of health care resources.⁶ The "normative" objections include the "humanitarian", the "liberal" and the "fairness" objections.

The "humanitarian" objection states that we are obliged to help people who really require help, irrespective of what caused them to be in such a position. Obviously this only holds for situations in which assistance is possible. An example would be a person who is a heavy smoker and develops angina pectoris, who is at risk of a myocardial infarction and who requires coronary artery stenting. Even if one argues that this is a self-inflicted lifestyle disease, most people would not deny him treatment.⁶

The "liberal" objection argument holds that denying a person health care on the basis of individual responsibility would violate that person's other rights. The "fairness" objection relates to the fact that issues beyond the individual's control influence that person's choices and that therefore s/he cannot be held liable to pay for such treatment.⁶ An example of such an issue would be a genetic predisposition to develop diabetes or cancer, which may be precipitated by obesity or smoking. Poor people have limited choices and they are also more prone to poorer health. Health policies which penalise unhealthy or risky behaviour would impose a disproportionate financial burden on poor people

than on the rest of society.⁷ As Cappelen phrases it, "If people are forced to pay for their own treatment when the need for it can be said to be self-inflicted, then we are holding individuals responsible for too much."⁶

The practical objections to holding people responsible for their health choices are (i) that information regarding the patient's past history and behaviour may be lacking and this may negatively influence the doctor-patient relationship if the doctor denies the patient treatment based on incomplete facts; (ii) the causal relationship between behaviour and health outcomes is often not clear; and (iii) judgements about people's health care choices may be moralistic and unjustified.⁶

A POTENTIAL SOLUTION: A LIBERAL EGALITARIAN RESPONSE

The "liberal principle" or principle of responsibility, states that people should be held accountable for their choices, and the "egalitarian principle" or principle of equalisation, states that people who make the same choices should have the same outcomes. In terms of individual responsibility for health, this implies that individuals should be held responsible for their *choices*, but not the *consequences* of their choices.⁶ This would allow for the fact that unhealthy or unsafe behaviour may not have the same consequences for different individuals, and that luck may play a part in this. One way of holding people responsible for their choices would be to impose taxes on those choices, for example, on smoking or alcohol consumption. This can obviously not apply to all cases or risky behaviour: it is not possible to tax people for lack of exercise or practising unsafe sex! In addition, low income families would be disproportionately disadvantaged by across-the-board taxes, and in any case, higher taxes do not usually translate into altered behaviour.⁶

Liberal egalitarianism states that we can only hold people responsible for choices affecting their health if we can be certain that the illness resulted from those choices; if the illness is not life-threatening; if the illness does not limit the person's other rights; and if the cost of treatment of the illness is low and the patient can afford it.⁸

WHAT IS THE ROLE OF THE HEALTH CARE PROFESSIONAL?

The health professional should not be judgmental: we should not blame patients if risky or unhealthy health behaviour results in illness. We should, however, advise patients regarding potential changes that they can implement in order to improve their health. We also have a role to play in educating patients, funders and other professionals, and as patient advocates.

CONCLUSION

So, how do we encourage people to take responsibility for their health, and include this responsibility into public

health policies and other funding decisions, without unfairly penalising people for consequences over which they have little control? Andre and co-authors state, "We need to assess carefully the different appeals to justice, the benefits and harms of penalties, and the extent to which we are justified in holding people responsible for the consequences of their behaviours."⁷ I believe there are legitimate reasons to limit people's access to health care if they are not prepared to implement changes in behaviour. In this way for example, I believe a health care system may justifiably refuse a patient a liver transplant if the recipient is going to continue abusing alcohol, even though this would be a life-limiting decision. It becomes more difficult in the case of an obese diabetic, and even more difficult when a child asthmatic is non-adherent.

I believe that we ought to think very carefully about responsibility in health care and allocation of scarce resources, and we need to debate the issue openly in public discussion forums. Discussion and debate are important, but we have to recognise that the practical implementation of such a policy is fraught with difficulty, especially in a country such as South Africa where there are massive discrepancies between people's socio-economic situations. Two potential ways to include personal responsibility for health, in resource allocation for health care, are to include it as a criterion in what is included in a basic health care package, or to utilise it in determining taxes or positive incentives in a funding or public health model.⁹

REFERENCES

1. Norman R, Bradshaw D, Schneider M, et al, and the SA CRA Collaborating Group. A comparative risk assessment for South Africa in 2000: Towards promoting health and preventing disease. *S Afr Med J* 2007;97:637-41.
2. Mayosi BM, Flisher AJ, Lalloo UG, et al. The burden of noncommunicable diseases in South Africa. *Lancet* 2009;374(9693):934-47.
3. Bender BG, Rand C. Medication non-adherence and asthma treatment cost. *Curr Opin Allergy Clin Immunol* 2004;4:191-195.
4. National Patients' Rights Charter <https://www.westerncape.gov.za/general-publication/patients-rights-and-responsibilities>. Accessed 30 June 2015.
5. Schmidt H. Patients' charters and health responsibilities. *BMJ* 2007;335:1187-1189.
6. Cappelen AW, Norheim OF. Responsibility in health care: a liberal egalitarian approach. *J Med Ethics* 2005;31:476-480.
7. Andre C, Velasquez M, Mazur T. Voluntary health risks: Who should pay? <http://www.scu.edu/ethics/publications/iie/v6n1/voluntary.html>. Accessed 2 April 2015.
8. Cappelen AW, Norheim OF. Responsibility, fairness and rationing in health care. *Health Policy* 2006;76:312-319.
9. Buyx AM. Personal responsibility for health as a rationing criterion: why we don't like it and why maybe we should. *J Med Ethics* 2008;34:871-874.

CIPLA LAUNCHES FIRST-TO-MARKET GENERIC CICLESONIDE

*Cipla is proud to announce **CICLOVENT** pressurized metered-dose inhalers - Targeting Large and Small Airway Inflammation in Asthma.*

Ciclovent, an inhaled corticosteroid, is indicated in adults and adolescents for the prophylactic treatment of asthma. Each **Ciclovent** inhaler delivers either 80 µg or 160 µg of ciclesonide per puff. **Ciclovent** contains small ciclesonide particles which sufficiently penetrate into the smaller airways of the lungs^{1, 2}. Ciclesonide has a total lung deposition of 52%³. Ciclesonide is highly lipophilic enhancing its slow release in the lung^{4, 5}.

Details as follows

PRODUCT NAME	ACTIVE INGREDIENTS	PACK SIZE	SCHEDULE	NAPPI CODE	S.E.P. EXCL. VAT	S.E.P. INCL. VAT	SAVING VS. ORIGINATOR ⁶
Ciclovent 80	Ciclesonide	120 doses	3	720711001	R 196.00	R 223.44	30%
Ciclovent 160	Ciclesonide	120 doses	3	720735001	R 349.40	R 398.31	50%

REFERENCES

1. Berger WE. Ciclesonide: a novel inhaled corticosteroid for the treatment of persistent asthma – a pharmacologic and clinical profile. *Therapy* 2005; 2(2):167-178.
2. Hoshino M. Comparison of Effectiveness in Ciclesonide and Fluticasone Propionate on Small Airway Function in Mild Asthma. *Allergol Int* 2010; 59(1):59-66.
3. Newman S et al. High lung deposition of 99mTc-labeled ciclesonide administered via HFA-MDI to patients with asthma. *Respir Med* 2006; 100:375-384.
4. Nave R, et al. In Vitro Metabolism of Ciclesonide in Human Lung and Liver Precision-cut Tissue Slices. *Biopharm Drug Dispos* 2006; 27: 197-207.
5. Nonaka T et al. Ciclesonide uptake and metabolism in human alveolar type II epithelial cells (A549). *BMC Pharmacol* 2007; 7:12.
6. DoH Price Approval.



For further information, please contact Dr Jaco van Zyl at 021 917 5620