Invitation to Conference

THE ETHICS OF HEALTH INCENTIVE PROGRAMS

Date: December 19th/20th, 2014
Venue: Munich Centre for Ethics, Room M210, Ludwig-Maximilians-Universität München, Geschwister-Scholl-Platz 1,80539 München, Germany

Organisation: Dr. Verina Wild (Institute for Biomedical Ethics and History of Medicine, University of Zurich), Dr. Anca Gheaus (Department of Philosophy, Umea University and University of Sheffield), Dr. Jan-Christoph Heilinger (Munich Centre for Ethics, LMU Munich)

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Some recently proposed health policies and programs aim to encourage individual responsibility with respect to lifestyle choices. One way of advancing this goal is to provide individuals with incentives to live healthy lives. For example, individuals may be offered discounted health insurance rates if they adopt healthy lifestyles, or they may be given vouchers to purchase healthy food or use fitness centres. Such programs are forms of the so called “nudging” approaches, meant to motivate people without coercively interfering with their private choices and to improve health outcomes without regulating the market for products that are detrimental to health. This conference addresses a range of questions that bear on the normative status of health incentive programs and policies: How should we balance autonomy, solidarity and justice in health incentive policies? How should we define and address vulnerability, stigmatization and personal responsibility in health incentive programs? Which responsibility do health incentive research projects carry for possible future value changes in health care systems? How can different theories of justice help us think about health incentive programs? Which questions arise from a global ethics perspective on health incentive programs?

Speakers:
Rebecca Brown, Health Services Research Unit, University of Aberdeen
Angus Dawson, Medicine, Ethics, Society & History (MESH), University of Birmingham
Nir Eyal, Division of Medical Ethics, Harvard Medical School
Anca Gheaus, Department of Philosophy, Umea University and University of Sheffield
Alexander Hevelke, Department of Philosophy, Ludwig-Maximilians-University of Munich
Samia Hurst, Institute for Ethics, History, and the Humanities, University of Geneva
Yashar Saghai, Berman Institute of Bioethics, Johns Hopkins University
Sridhar Venkatapuram, Department of Social Science, Health and Medicine, King’s College London
Kristin Voigt, Department of Philosophy and Institute for Health and Social Policy, McGill University
Verina Wild, Institute for Biomedical Ethics and History of Medicine, University of Zurich

Program:

Friday, 19th December 2014		
9.00-9.10	Welcome by the conference organizers	
Introduction to the ethical challenges of health incentive programs		
9.10-10.00	Ethics of up-scaling: From research to implementation of health incentive programs	*Verina Wild, Alexander Hevelke*
10.00-10.30	Coffee break	
10.30-11.20	Personalized health incentives and varieties of justice concerns	*Yashar Saghai*
Social values in health care systems		
11.20-12.10	Snakes and ladders: interventions and the place of liberty, solidarity and justice	*Angus Dawson*
12.10-13.40	Lunch break	
13.40-14.30	Social values and the 'corruption' argument against health incentives	*Rebecca Brown*
14.30-15.00	Coffee break	
Health incentives and luck egalitarianism		
15.00-15.50	Political relational goods, justice and unconditional access to health care	*Anca Gheaus*
15.50-16.40	Does the harshness objection to luck egalitarianism backfire?	*Nir Eyal*
19.00	Speakers' dinner	

Saturday 20th December 2014		
Vulnerability, health care and justice		
9.30-10.20	Can nudging protect vulnerable persons?	*Samia Hurst*
10.20-10.50	Coffee break	
10.50-11.40	Too poor to say no? Health incentives and low-income populations	*Kristin Voigt*
Health incentives programs at a global level		
11.40-12.30	Health capability and health incentives – a global and grounded perspective	*Sridhar Venkatapuram*
12.30-12.40	Closing words by the conference organizers	

Registration:
The conference is open for researchers and practitioners from all relevant fields. Registration is free but we have a limited number of seats. Please register by the **25th of November 2014** under **mke@lmu.de** with name, title and affiliation.

Please find a detailed program under: http://www.ethik.uzh.ch/ibme/news/health-incentive-programs-ethics-verina-wild.html

For further information please send an e-mail to Veronika Sager: mke@lmu.de or Dr. Verina Wild: wild@ethik.uzh.ch.

Abstracts:

Ethics of up-scaling: From research to implementation of health incentive programs *(Verina Wild, Alexander Hevelke)*

An ethical evaluation of health incentive research projects shows that significant ethical problems in relation to the studies themselves are unlikely to occur. Especially issues such as discrimination of certain groups, increase of social injustice and the erosion of values in health care such as solidarity – all of which have been discussed in relation to health incentive programs – are not expected to occur to a worrying extent in a small-scale research project. However, a large implementation of such across one or more continents might bring with it undesired shifts in fundamental values in health care. This paper discusses which responsibility small-scale studies have for possible fundamental effects on ethical values after wide implementation. Are, for example, precautionary measures which could be tested within the small-scale studies sufficient to manage possible large and unintended value-shifts? The participatory role of bioethicists in theory and practice is also discussed.

Personalized Health Incentives and Varieties of Justice Concerns *(Yashar Saghai)*
Health incentives have ignited a heated debate surrounding their impact on self-determination, responsibility, solidarity, and justice. However, these debates remain at a very generic level. In an effort to find a more appropriate approach that combines the big picture with reflection on specific types of incentives, I focus on health incentives as they are employed in certain programs. These incentives are voluntary, personalized, in-kind and health-related, small, overt, targeted, and involve private and public actors with direct contact with the beneficiaries. My question is whether justice concerns with health incentives are lessened or exacerbated when these features are present. I discuss four varieties of justice concerns. First, health incentives are unfair towards non-participants. Second, they are unjust because they aggravate disadvantages or inequalities, or at least fail to alleviate them. Third, they have an overall negative impact on justice-related social norms, including solidarity. Fourth, they contribute to epistemic injustice by undermining the ability of beneficiaries to co-generate social meanings that structure their understanding of health practices.

Snakes and ladders: interventions and the place of liberty, solidarity and justice *(Angus Dawson)*
Many ethical discussions of public health policy, implicitly or explicitly, give liberty a special place. For example, the Nuffield Council of Bioethics' (2007) report on public health ethics, despite claims to outlining a 'modified' liberalism, do so in their proposal of the 'intervention ladder' as a tool for policy makers. In this metaphor, the steps on the ladder range from no action to where choice is eliminated. The message is clear that policy makers are to be discouraged from climbing this ladder. In this paper I argue that this way of conceptualizing public health ethics is inherently flawed, as it provides no obvious means to engage with other important values such as solidarity and justice. I argue that whilst liberty is, obviously, an incredibly important value, our approaches to public health ethics need to do more than merely maximize liberty. This requires a pluralistic approach to the relevant values, so that, for example, liberty can be balanced against equity. I argue for an approach to public health ethics that allows some ladders to be climbed where they are the best way to attain various important ends, and that there is a role for government in helping citizens avoid the various snakes of life through the assurance of the conditions of health.

Social values and the 'corruption' argument against health incentives *(Rebecca Brown)*
Incentives offer a potential means of promoting healthy lifestyles and improving health. Whilst evidence as to the efficacy of incentives as health promotion tools is inconclusive, debates surrounding the ethics of 'paying people to be healthy' raise the question as to whether incentives, even if they do work, should be used. A vocal critic of the use of financial incentives to promote certain pro-social behaviours is Michael Sandel. In his book What Money Can't Buy and elsewhere, Sandel articulates a concern which initially seems appealing and plausible: that the introduction of money into certain spheres of life results in the commodification and, subsequently, the corruption of certain values. In this

paper I consider how Sandel's argument applies in the case of incentivising healthy behaviour. I argue that, whilst superficially appealing, it is not at all clear that money will systematically corrupt social values, nor that changes in social norms as a result of monetary transactions need be viewed as socially destructive.

Political relational goods, justice and unconditional access to health care *(Anca Gheaus)*

In discussions about the distribution of basic resources we often think about justice and political relational values like solidarity, non-domination, or non-marginalisation as potentially competing with each other. In particular, those who believe that just distributions ought to track individual responsibility – for instance, luck-egalitarians – think that individuals can lose their entitlement to goods such as medical care through their own, irresponsible, behaviour. Yet, If we think about the above-mentioned political relational values as contributing to people's quality of life, then one understanding of (luck egalitarian) justice requires us to be concerned with people's access to political relational goods. I suggest that solidarity, non-domination and non-marginalisation should be understood as being themselves proper *distribuenda* of justice. If so, health incentive programs can only be just if they advance, or at the very least don't undermine, these political relational goods. On this matter, at least, various traditions of thinking of justice – in particular democratic equality and some stands of luck egalitarianism – can be allies in requiring unconditional access to health care. I explain that the most serious objection to this way of framing the connection between justice and political relational goods is that it relies on mild perfectionist assumptions about the role of the state. This may be a theoretical price worth paying.

Does the harshness objection to luck egalitarianism backfire? *(Nir Eyal)*

Luck egalitarianism initially seems to demand an exceedingly harsh allocation of basic health resources. Critics Marc Fleurbaey, Elizabeth Anderson, Daniel Wikler, Samuel Scheffler, and Norman Daniels accuse luck egalitarians of supporting the harsh abandonment of reckless drivers who hit trees, of gluttons whose unhealthy diets lead to chronic disease, and of bons vivants whose taste for unprotected sex results in their infection. Some of these critics use the alleged harshness of luck egalitarianism in the health sphere to motivate an alternative egalitarian theory, namely, democratic equality. Luck egalitarian Shlomi Segall concedes that democratic equality "easily averts the abandonment objection" (he merely insists that, with limited moral acrobatics, luck egalitarians can avert that objection as well).

I shall argue:

1. The harshness objection arises for democratic equality as well.
2. A central reason why both luck egalitarian and democratic egalitarian recommendations seem too harsh is the biasing influence of the unrelated and irrelevant "rule of rescue" mentality.
3. Outside immediate rescue situations, the force of the harshness objection wanes and personal responsibility feels more relevant.

Can nudging protect vulnerable persons? *(Samia Hurst)*

It is generally admitted that vulnerable persons deserve special attention, care or protection. And one can define vulnerable persons as those having a greater likelihood of being denied adequate satisfaction of some of their legitimate claims. How do policies based on health incentives or nudges affect vulnerability? Questions regarding the moral risks of nudging have tended to focus on whether non-coercive measures such as nudging can nevertheless problematically impinge on individuals' autonomy, or may increase rather than diminish existing inequalities. Although this may be true of certain forms of nudging, others may actually protect claims to autonomy and freedom, and some forms of inequality. This is also true of other claims: physical integrity, communal belonging, and the social bases of (self-)respect, can all be protected rather than rendered more fragile by some forms of nudging. Nudging, then, can protect vulnerable persons. Other claims, however, may indeed be rendered more fragile through nudging. Providing exchangeable currency in exchange for healthy behavior could crowd out other forms of social provision. Inasmuch as we pick and choose which behaviors to target, we may stigmatize some unhealthy behaviors already at risk of being excessively moralized.

Some forms of nudging are better described as sanctions; when they are dealt out on persons with little control over the targeted behavior, this constitutes insufficient impartiality in the exercise of authority. Examining how policies based on nudging can affect vulnerability provides a framework from which to distinguish various forms of nudging and their ethical implications, and to identify where protections for vulnerable individuals should accompany such policies.

Too poor to say no? Health incentives and low-income populations *(Kristin Voigt)*
Incentive schemes have become an increasingly popular means of attempting to improve health behaviours. Many such incentives explicitly target poor populations, where health burdens – including health burdens related to particular health behaviours – are often significantly greater than in more advantaged groups. Perhaps most prominently, incentives are increasingly employed in low- and middle-income countries in the form of so-called conditional cash transfers (CCTs), which make cash payments to poor populations conditional on recipients' meeting certain requirements. Incentive programmes specifically targeting disadvantaged communities have also been implemented in industrialised countries, for example as part of the Scottish 'Give it up for baby' programme. Even universal incentive schemes that do not target any particular group can have a differential impact on low-income vis-à-vis high-income recipients. In this paper, I consider the normative implications of such effects. I argue that many types of health incentives have problematic implication for low-income populations. Conversely, incentive schemes can be more acceptable when they do not operate primarily through their effects on individuals' incentive structures but rather influence health outcomes through other, secondary mechanisms.

Health capability and health incentives – a global and grounded perspective *(Sridhar Venkatapuram)*
The capabilities approach to social justice and the philosophy of 'liberal paternalism' behind nudging health policies have a lot in common. Both approaches aim to create social environments that enable people to achieve outcomes that are valuable. The major objection, among many, to nudging is that it is violates personal liberty by making people act or achieve outcomes that they do not directly, explicitly or consciously endorse. Such an objection can also be made against the capabilities approach. Indeed, this was Ronald Dworkin's main objection to the capabilities approach—that it endorses/forces people to live one particular kind of good life. In this paper, I acknowledge the wide latitude for paternalism/maternalism in the capabilities approach which gives it common cause with nudging advocates. At the same time, I identify other principles central to the capabilities approach such as non-domination, liberty, and dignity that constrain the scope of social intervention into individual capabilities. Focusing on health capability, and health outcomes, I will also discuss how nudging of various kinds has always been part of health development programmes, sometimes with disastrous consequences such as family planning programmes using incentives. The central question, I assert, is not whether or not to nudge individuals to achieve better health or wellbeing, but what are the right principles to govern the social interventions that aim to create change in people's lives? Indeed, justice demands there is social intervention to alter social arrangements such that individuals are 'emancipated' --more capable of achieving health and wellbeing. However, rather than one universal metric(s) to judge the morality of such social interventions, evaluation of the morality of interventions has to be done across multiple dimensions. Unsurprisingly, I will argue that the capabilities approach is best suited to bring together the knowledge from the natural and social sciences about human beings with normative reasoning in order to identify and evaluate the relevant multiple dimensions of social interventions.