## *Premature Death and Disability*

One of the most important goals in health policy should be to reduce the number of those who either die or become severely disabled early in life. It is well known that in industrialized countries e.g., in which the average life expectancy now ranges between 70 to 76 years for men and 75 to 82 years for women, about 30% of all men and 20% of all women die before the age of 65.[11] An additional 5% are severely disabled at that age. For the purpose of this essay I regard a death as premature if it occurs significantly before average life-expectancy in society, say at age 65 or younger in the U.S.. I will justify this threshold below when I have introduced what I believe is the nature of our obligation to save lives. Severe disability is meant to cover cases of significant impairment of mental or physical functioning, such as psychosis, blindness, paraplegia, or constant pain and discomfort.

Premature death and disability are usually perceived as especially tragic because they frustrate ongoing projects and relationships. Any moral theory that gives any weight at all to benevolence would thus advise us to try to reduce the

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[11] U.S. Congress, OTA (1993)

burden of such premature death and disability. The disagreements start when the question is raised if we as a society are under an obligation to try to reduce such premature death and disability, what the nature of that obligation is, and what its limits are. To explore these issues, I will first consider the most common causes of such tragedies and whether they can be averted. Then I will address the question of what it would take to avert these causes. In particular, do we face a serious scarcity of resources when it comes to ameliorating such conditions?

The diseases that account for most of the early death and disability in men in industrialized countries are heart disease, cancer, and accidents. Together these account for more than 60% of all deaths before age 65. For women the situation is similar, with heart disease and cancer also being the leading causes of early death and disability.[12]

It is well established that a large percentage of early death and disability could be averted through more and better medical care as well as through preventive interventions. The greatest impact would come from primary care and the screening and treatment of individuals with risk factors that are known to predispose for serious illnesses. Examples for this are blood pressure and cholesterol screening, as well as

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12 (ibid)

screening for colorectal, breast, and other cancers.

Among the measures an individual can take to reduce the likelihood of premature death and illness, smoking cessation, diet modification, and regular exercise rank first. Among these smoking cessation is clearly of the biggest importance because smoking contributes both to the burden from heart disease and from cancer.[13] It is estimated that smoking is responsible for 30% of all deaths from cancer and for 25% of all heart disease deaths.[14] Diet is an established determinant for the likelihood to develop heart disease and cancer also and ranks second after smoking, accounting for an unknown number of all cases of heart disease and an estimated 35% of all cases of cancer.[15]

Given that a large number of cases of premature death and disability could be averted, how much should society spend to reduce the number of those who are at risk? Is there anything special from the point of view of social justice when an individual dies or becomes severely disabled relatively young? Given the scarcity of resources, which is part of the background condition of any health care system, as a society do we have a special obligation to try to avoid

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13 MacKenzie (1994)

14 Doll & Peto (1981)

15 Hennekens (1994)

premature death and disability? These are questions that are part of a more general question, namely what should the functions of the health care system be?[16]

These questions are not new. But I would argue, they have recently become more pressing for the following four reasons. First, in this century we have witnessed a dramatic increase in average life-expectancy in both industrialized and nonindustrialized countries. This has widened the range of life-expectancy and of the prospects for disability-free life within societies. Second, the potential for helping those who are threatened by premature death and disability has greatly increased, in particular through advances made in medical care, epidemiology, and health policy. Third, the potential costs of prevention and treatment have increased through the availability of new and better technology. And finally, we have only recently become able to identify beforehand those who are at the highest risk for developing diseases leading to premature death and disability. This not only increases our potential to help those at risk but also transforms their status from a statistical bearer of risk to an identifiable individual. This makes a difference from a moral point of view, because if we could have or have identified an individual as a risk bearer, without doing anything about this risk, we might be acting wrongfully

16 Daniels (1985)

against this particular individual.

How severe are the resource constraints for avoiding or postponing premature death and disability? It is often asserted that prevention and early treatment averting premature death actually save money which would otherwise be spent in the treatment of advanced disease stages. If this were generally true, spending for the prevention of premature death and disability might pay for itself.

Although cost saving does occur in some cases, it is not generally the rule and there are some cases that are extremely expensive to address.[17] Such cases include, for example, those that can only be successfully treated if they are detected through screening programs which are relatively inefficient because few test as true positives and many test as false positives. This is the case for breast cancer screening and cholesterol screening in some relatively young age brackets.[18] Other cases of premature death prevention that are extremely costly involve safety-regulations or injury prevention measures which seem to be more expensive as a group than medical care in terms of dollars per life-years saved. The costs for safety-regulations can be as high as an

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17 Weinstein (1990)

18 Tengs (1994)

estimated 100 billion per life-year saved.[19] Thus we could spend 10% of the current estimated annual expenditures for health care in the U.S. on saving one statistical life-year.

Clearly therefore, industrialized nations could almost certainly devote a much larger share of their GNP to the prevention of premature death and disability than they do now and still get some additional benefits. This is especially so since, I will argue below, we should regard prematurity in death and disability at least in part as dependent on the average life expectancy in a society. This would imply that the definition of premature death is dynamic, and some deaths will always have to be regarded as premature.

## *Justice and the Functions of Health Care*

There is no scarcity of proposals about what justice demands with respect to the structure of health care systems.[20] Most of the proposals made rightly focus on issues of distributional justice because of the fact that there is a wide range of what kind of health care people enjoy (in particular, but not only in the U.S.), and health

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19 (ibid)

20 Buchanan (1983)

care costs are rising in all industrialized countries.[21] One way to explore justice in health care is to ask whether there is a right to health care. This is an important question because of the political power rights claims do enjoy in western democracies. We should realize however that the nature of our obligations to provide health care for others ultimately determines what kind of health care services someone could claim as a right and what the limits of those claims are. Still it is useful to explore what a right to health care could mean according to defenders of the most widely held theories of justice.

The theory which is most closely linked to health economics as practiced in the U.S., and also to the use of modern techniques of policy analysis, is utilitarianism.[22] In utilitarianism there are no deontologically justifiable obligations or rights. It is an important theoretical question if utilitarianism is compatible with the institution of rights at all, but to the extent that it is, it can be said to advocate only those rights that in the long run tend to maximize utility.[23] The moral obligation of an individual to support such rights would follow from a more general obligation, for example deriving from universal benevolence

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21 U.S. Congress, OTA (1993)

22 Brock (1993)

23 Lyons (1994)

or mutually advantageous conventions. A right to health care would follow from the empirical assumption that extending such a right would contribute to the maximization of utility. The services covered, as well as the budget set for such a right to health care, would likewise be regulated by the utility maximization rule.

Alternatively, communitarian theories of justice would, simplifying enormously, grant a right to health care for all members of the community if doing so would express the shared understanding of what justice in health care means for the community in question.[24] This would lead to quite different health care entitlements in different societies, since different societies live by distinctly different sets of shared values. It would imply no right to any kind of health care if that is what best expressed the values of a particular community.

Finally, for liberal theories of justice, a right to health care is not automatically included in any just society either. Liberal theories do, indeed, grant certain rights to the individual that neither utilitarian nor communitarian considerations can overturn. The question is, should health care be part of the set of rights granted to everyone. Libertarian liberals deny this, claiming that doing so would

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24 Walzer (1983)

either violate more central rights of tax-payers or of health care professionals.[25] They may regard enforced taxation for the purpose of granting health care rights as a form of forced labor. Likewise, forcing the medical profession to provide health care services to all members of society has been regarded as a significant infringement on their personal liberty to treat whom they want.

Among those liberal theories that do support a right to health care one can distinguish between two groups. On the one hand there are those who claim that health care is a right that follows from our more general obligation to provide every citizen with a fair share of resources or what Rawls has called "primary goods". The term refers to all-purpose resources and privileges that would be desired by those who knew what is typically required for pursuing a wide variety of life-plans.[26] On the other hand are those who claim that the nature of the obligation to provide health care is different than the obligation to provide resources or primary goods and should be prior to the rights following from that obligation. The best example for this kind of insulation of health care from other social goods was developed by Norman Daniels. He argues that a right to health care follows from our obligation to provide everybody with

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25 Nozick (1974)

26 Dworkin (1993)

equal opportunities before we start distributing primary goods or resources.[27]

All of these approaches have been criticized from various perspectives, and I will not repeat these criticisms here.[28] Instead I want to put forward one particular kind of criticism that appears to apply to all of the theories surveyed above and offer my own suggestion how we could make progress in clarifying our intuitions about justice in health care by avoiding this problem. This kind of criticism also provides us with some important concepts for how we should think about the problem of preventing premature death and disability specifically, and can explain why those comprehensive theories of justice in health care which are open to this criticism cannot give us a satisfying answer to that problem.

What all the above theories share is the assumption that our obligation to provide any particular form of health care can only follow from a more general obligation to provide other quite different forms of health care. Utilitarians believe that obligations to provide any form of health care could only follow from a quite general obligation to maximize utility. Communitarians hold that the obligation to provide

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27 Daniels (1985)

28 Buchanan (1983); Emanuel (1991)

any form of health care would follow from a general obligation to share and express the values of a particular community. Among liberals there are those who hold that health care obligations are part of the obligations towards assuring fairness in the distribution of resources and those who argue they follow from our obligations to provide everybody with equal opportunities.

I want to challenge this central assumption, namely that all forms of health care are covered by one kind of obligation, and will do so from a broadly Kantian point of view. Instead, I claim that there is a specific type of obligation concerning what I propose to term the central functions of health care that is different from our obligations with regard to other, non-central types of health care.

None of the general obligations, derived from the other theories, does justice to the reasons why, I believe, we have a particular obligation to prevent premature death and disability. Premature death prevention and the protection against severe disability, I contend, are obligations we have as part of respecting others as moral agents. Thus, avoiding premature death and disability are the central functions of health care, since they follow from an obligation more important than utility considerations, the expression of

shared values, equality of opportunity, or fairness in resources. For purposes of justice, therefore, we should not regard health care as a single social good, and should regard our obligations to provide everybody with the services needed for the central functions of health care as prior to providing any other set of services. For other functions of health care there are other general obligations which provide a more plausible reason to provide the corresponding health care services.

It is often claimed that Kantian ethics lacks the resources needed for practical ethics or "real life" policy issues and it has been criticized as an empty formalism devoid of defensible practical implications.[29] Although I think that this criticism has been successfully rebutted by Kantian moral philosophers, it is somewhat surprising that in the current Anglo-American debate about justice in health care there exists so far no comprehensive Kantian theory of just health care. Although my effort is not such a theory either, it is guided by the conviction that Kant's moral philosophy does have a lot to contribute to this debate. I believe that broadly Kantian reasoning can help us to understand the special moral importance of the obligation to save lives from death and severe disability while it also allows us to limit the costs of this central function of

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29 Mill

health care in a principled way.

In looking at justice in health care from a Kantian point of view I also hope to stimulate the debate about how Kantianism can be used to understand specific matters of social justice. It has been argued that Kantian ethics provides the most secure foundation for liberalism.[30] The question is, is it also capable of specifying reasonable solutions to specific questions of justice such as justice in health care. I believe it is.

30 Rosen (1994)