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Commentary

There Are Many Purposes for Conditional Incentives to Accessing Healthcare

Comment on “Denial of Treatment to Obese Patients—the Wrong Policy on Personal Responsibility for Health”

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Abstract

This commentary is a brief response to Nir Eyal's argument that health policies should not make healthy behaviour a condition or prerequisite in order to access healthcare as it could result in the people who need healthcare the most not being able to access healthcare. While in general agreement due to the shared concern for equity, I argue that making health behaviour a condition to accessing healthcare can serve to develop commitment to lifestyle changes, make the health intervention more successful, help appreciate the value of the resources being spent, and help reflect on the possible risks of the intervention. I also argue that exporting or importing the carrot and stick policies to other countries without a solid understanding of the fiscal and political context of the rise of such policies in the US can lead to perverse consequences.

Keywords

Personal Responsibility for Health, Obesity, Carrots and Sticks, Chronic Diseases, Public Health Ethics

I recently had a long discussion with an anesthesiologist friend who spends most of his time assisting with bariatric surgeries. The National Health Service in England, my friend's employer, provides British citizens with bariatric or gastric band surgery to those with life-threatening obesity when other interventions such as lifestyle changes have not worked. In light of the rise in rhetoric and policies about personal responsibility for health in the United States, United Kingdom and other places, I was curious to hear the views of someone who works day to day with obese people. Issues related to obesity, personal responsibility for health, and reward and punishment health policies are often entangled in discussions. I wanted to see how he parses them out. Among the many interesting dimensions to his perspective on obesity and obese individuals, what struck me most was the mixed emotions he had about the interface between obese individuals and medical services which in England are fully funded public services.

Given that he bore the primary responsibility for rendering a patient unconscious for the surgery, he is responsible for managing a significant part of the risks involved with the surgery. In essence, the burden of personal responsibility for

managing risks passes from the patient to him during a period of time. This burden of managing the risks associated with applying anesthesia as well as awareness of the financial costs of the surgery and rates of success of gastric-band surgeries have motivated him to spend some time with each patient prior to the surgery. During this conversation he explains the severity of the risks involved with the surgery as well as the need to see the surgery as one last chance to make some significant changes in their life if they truly want to live longer and healthier as well as not to waste the public resources and opportunity. This conversation is repeated before he applies the anesthesia to make them unconscious on the surgery table in order to act like a hypnotic suggestion.

Eyal proposes the rule of thumb that ‘any conditional incentive for healthy choice should be in a currency other than the basic means to that health choice’ (1). This soft principle as well the article is linked to obesity but with a view to being applicable more generally to other health issues. Eyal points to the incoherence of linking certain health behaviour to benefits or ‘carrots’ which themselves are health improving goods and services. In essence, he is making the point that individuals who need the healthcare goods and services the most may be the least likely to adhere to the conditions to access those goods and services. In order to address this absurd situation, Eyal suggests that doctors, managers and health policy makers should have alternative ‘carrots and sticks’ aside from providing access or denial to healthcare.

While I am largely sympathetic to Eyal's analysis, there are aspects to his article and principle which deserve closer scrutiny. Eyal is very right to point out the incoherent and absurd situations arising from the carrots and sticks approach to obesity and other health issues. He is also quite right to point out that some of the causes of these absurd situations lie in doctors, managers, and policy makers simply trying to get rid of ‘difficult’ (i.e. expensive) patients from their systems. And, as Eyal briefly mentions, there is a great amount of discrimination against obese individuals, particularly in developed countries. Carrot and stick policies, particularly stick policies, are often motivated from underlying discrimination or judgments about

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moral inadequacy or weakness of will. What comes out of the article most clearly is that Eyal is fine with the carrots and sticks approach to health policy, he just wants to help clarify what should and should not be the carrots and sticks. In particular, he proposes that the ‘currency’ or pathways to be healthy for an individual should not be made a condition to access to the same pathways to health.

Setting aside possible malicious background reasons for pursuing a carrot and stick approach, Eyal’s soft principle seems a pretty good one. Carrots or sticks in a currency other than the means to health would ensure that individuals who need the means the most would still have access to health benefits. And the carrots and sticks in a non-health domain would, hopefully, increase the number of individuals accessing the means to health. Eyal is not concerned if those increases happen from more socially advantaged individuals. Any improvements in health, he believes, are worthwhile.

It so happens that in order to access the risky and expensive bariatric surgery in the UK or the US, obese individuals have to first show some sort of behavior change over a period of many months prior to a tentative surgery date. They must show evidence that they are reducing their caloric intake, are more physically active, participating in social support groups, and other things. This is something that Eyal’s principle would be against. The success of bariatric surgery depends very much on whether the patients make some drastic changes to their lifestyle, including caloric intake, during many months after their surgery. In fact, such changes are expected to be life-long. If the individuals do not adopt these changes, then the bariatric surgery is largely a wasted opportunity and resources. The period of behavior change leading up to the surgery functions as a mechanism for practicing and developing commitment to lifestyle changes. Moreover, this conditionality also attempts to ensure that the patient appreciates the riskiness, expense, and post-surgery life-style changes that will need to be sustained.

Eyal does not appear to recognize this particular role of conditionality. Even psychiatric patients and those who would like to avail themselves of detox services may need to meet conditions partly in order to show or develop a commitment to post-treatment life changes. That is, if you cannot manage to clean up and keep your appointments prior to detox or psych appointments, then it is unlikely you will fully benefit during and after the detox program or therapy. In different sub-specialties of medicine, professionals know which individuals are more likely to benefit from the actual therapy than others partly based on what the patient does prior to the intervention. Conditionality with respect to health pathways then can increase the chances of success for people to benefit from the intervention. In the domain of behavioral economics, it has been shown that even a superfluous commitment making exercise such as asking people if they will vote increases the number of individuals that actually do go onto vote (2).

Given that Eyal does not present his rule as a hard rule, I think it is plausible that where such conditionality is partly to engender commitment necessary for the success of the intervention, Eyal’s principle could be set aside without rendering it meaningless. So I move onto responding to other points in his discussion. First, Eyal’s attempt to link his previous work on carrots and sticks in the United States with health issues in Iran, and by implication other countries like Iran should be done with much more care. The interest in personal responsibility for health and

particularly carrot and stick policies in the United States and other countries is profoundly linked to their social and political conflicts and contexts. In particular, carrot and stick policies are directly linked to efforts to contain escalating healthcare costs and for others, containing the size of government. Simply attempting to apply the discussion about carrot and stick health policies to other countries, without an adequate discussion about the primary motivation for such policies could lead to many perverse consequences. In certain developing countries, advocacy of carrot and stick policies without the background discussion about what is giving rise to such policies in the US could actually justify slow or limited investments in healthcare.

A second drawback of simply transferring the discussions from the US context to other countries or developing guiding principles that sound universal is that they could really miss the mark. For example, in many developing and even rich countries such as those in the Middle East, obesity is not associated with shame or discrimination. In fact, it is associated with wealth and status. It is the poor or manual labourers who are ‘normal’ weight. And, in these countries applying carrots and stick obesity policies simply will not work because such individuals can afford to pay for healthcare privately. That is, the socio-economic gradient of obesity is the opposite in many countries to that of the United States. The simple importing of policies or reasoning that is in vogue in the US to other countries can lead to some peculiar policies. For example, the government of Dubai is offering a gram of gold for every kilogram of weight an individual loses (3).

Offering gold to the already wealthy for losing weight would be in line with Eyal’s principle, and much of the reasoning underlying carrot and stick health policies. However, such a policy and Eyal’s general agreement with carrot and stick policies does not sit right. The reason for wanting obese individuals to lose weight is that obesity constrains individuals from being able to fully live out their lives, most directly by leading to premature death. Seeing obese individuals as being constrained would alter the kind of policies directed at them. Instead, carrot and stick policies have started to shift the purpose of medicine away from the primary concern for the well-being of the patient. And from a public policy perspective, they conceptualize the citizen as a potential drain on public resources. Eyal’s effort to clarify the form of carrots and sticks may be plausible, but it is being done on top of or irrespective of commitments to a variety of foundational positions that should be examined much more carefully, especially in an international context.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author’s contribution

SV is the single author of the manuscript.

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