

Resource Allocation, Ethical Decision-Making and Vulnerable Populations

Catholic Health Care Ethics: Clinical, Social and Global
Concerns
February 28-29, 2008

Bridget Carney, PhD, RN
System Director of Ethics and Theology
PeaceHealth

Objectives

- To understand what is meant by the term “vulnerable populations”
- To be able to articulate the principles and values essential to Catholic Health Care in decision-making regarding health care resource allocation and vulnerable populations
- To be able to articulate tools for ethical discernment for health care resource allocation and how to utilize this process in serving both vulnerable populations and the common good.

QUESTIONS



- What image/thoughts come to mind when you read or hear these three concepts: *Resource Allocation, Ethical Decision-Making, and Vulnerable Populations?*



- What concerns and fears arise?

CASE EXAMPLES

- **University of Texas Medical Branch (UTMB) in Galveston, undocumented immigrants and cancer treatment.**
- **A remote setting: A 54 year old woman, mother of two children needing blood. She is transfused with all the blood in the community and no blood available for 24 hours.**

CASE EXAMPLES

- **Two working parents with 4 children, one with a disability requiring special care**
- **Flu pandemic or natural disaster (e.g. hurricane Katrina)**
- **A migrant farm worker who is a legal resident but has no health insurance**

CASE EXAMPLES

- **Undocumented immigrant requiring chronic dialysis (3 times a week) and no insurance coverage**
- **Undocumented immigrant, no insurance, paraplegic, hospitalized 6 months for decubitus care. Home now, with attendant care for 6 hours a day paid by the hospital, housing paid by Catholic Community Services.**

Vulnerable Populations

- Who are they?
- What do we mean?

THE STATISTICS

- Forty-Seven million without health insurance in the United States
- Pew Hispanic Center Source: Illegal immigrants represent about 15% of the nation's 47 million uninsured people.
- Health care costs in the US is costliest in the world—\$2.2 trillion annually (17 % of GDP)

VULNERABLE POPULATIONS

(Examples)

- The uninsured and underinsured
- Disabled persons
- Homeless persons
- Mentally disabled persons
- Immigrants and refugees
- Undocumented/unauthorized immigrants

VULNERABLE POPULATIONS

(Examples)

- **Persons with life threatening illnesses:**
 - Chronic illnesses
 - Terminal diagnoses
- **Persons with AIDS**
- **High risk mothers and infants**
- **Abusing families**

VULNERABLE POPULATIONS

- **What population(s) is/are missing?**

VULNERABLE POPULATIONS

- **The Concept of Universal Vulnerability:**
 - “Risk factors that influence health are so encompassing that any member of a population may, at any point in his or her life course or in some social circumstance, be vulnerable” (Danis and Patrick, 2002: 311 in [Ethical Dimension of Health Policy](#), Eds.-- M. Danis, C. Clancy, and L. Churchill).

Definition of Vulnerable Populations

- **“Vulnerable populations are those at risk at any particular point in time for unequal opportunity to achieve maximum possible health and quality of life because of differences in intrinsic and extrinsic resources that are associated with good health”** (Danis and Patrick, 2002: 311 in Ethical Dimension of Health Policy, Eds.-- M. Danis, C. Clancy, and L. Churchill).

Vulnerable Populations: Defined

- (AHRQ) These populations are **“made vulnerable by their financial circumstances or place of residence; health, age or functional or developmental status; ability to communicate effectively; presence of chronic or terminal illness or disability; or personal characteristics”** (Brock, 2002: 288 in Ethical Dimension of Health Policy, Eds.-- M. Danis, C. Clancy, and L. Churchill).

Vulnerable Populations: Defining the Term

- **Agency for Healthcare Research and Quality (AHRQ)**
 - **“Vulnerable populations are populations with special needs for or barriers to care from a variety of conditions or circumstances and less able than others to safeguard their own needs and interests”**(Brock, 283: 2002 in Ethical Dimension of Health Policy, Eds.-- M. Danis, C. Clancy, and L. Churchill).

Three Different Moral Categories of Vulnerable Populations

1. Those whose risk of poor health is caused by conditions that are themselves unjust (e.g. extreme poverty, lack of access to education or employment)
2. Those whose conditions causing their high health risks are an undeserved misfortune but not themselves a social injustice (e.g. genetic lottery)
3. Those who are at fault or responsible for their high health risks (e.g. high fat diet, high risk activities, sedentary lifestyles) (Brock, 2002: 290-294 in Ethical Dimension of Health Policy, Eds.-- M. Danis, C. Clancy, and L. Churchill))

Biblical Concept of “Vulnerable Populations”

- Old Testament:
 - “The marginal groups in society—the poor, the widows, the orphans, the aliens—become the scale on which the justice of the whole society is weighed. When they are exploited or forgotten neither worship of God nor knowledge of Him can result in true religion” Donahue, 1977:78 in The Faith that Does Justice, Ed. John C. Haughey.
 - “Right Relationship”

Biblical Concept of “Vulnerable Populations”

- New Testament:
 - Who are the Poor and Oppressed?**
 - The tax collectors, widows, physically ill, those possessed by spirits, prisoners?
 - The poor of the Beatitudes?
 - “The poor you will always have with you”

Mission of Catholic Health Care Ministry

- **As Catholic health care, we are a ministry continuing Jesus' mission of love and healing today. As provider, employer, advocate, citizen—we bring together people of diverse faiths and backgrounds. Our ministry is rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit (CHAUSA.org)**

Mission of Catholic Health Care Ministry

- **Providing compassionate, high-quality care for bodies, minds, and spirits**
- **Promoting health and well-being for all persons and communities**
- **Paying special attention to those who are poor, underserved, and most vulnerable.**
- **Acting to end poverty, injustice, and discrimination**
- **Using our resources responsibly**
- **Acting in harmony with the Catholic Church (CHAUSA.org)**

The Foundation of this Ministry: Catholic Social Teaching (CST)

- **Human Dignity**
- **Stewardship**
- **The Common Good**
- **Social Justice**
- **Care of the Poor**
- **Subsidiarity**

So far....

- We have an understanding of “vulnerable populations”.
- We have an understanding of the biblical understanding of the poor and vulnerable
- We have reviewed CHA mission statement for Catholic Health Care Ministry.
- We have highlighted significant principles of Catholic Social Teachings.

•How do these resources help us with ethically discerning health care resource allocation, specifically for vulnerable populations?

Resource Allocation

- Assumption is that resources are limited for creating the goods needed to promote human dignity and the common good
- Health care is only one component of creating the common good. There are competing claims, such as education, housing, environment, jobs, etc., that makes health care a limited resource.
- Artificial Scarcity—unjust health care system

**In Making Resource Allocation Decisions,
What is the Priority:
Health or Health Care?**

• Issues:

- A focus on access to health care risks missing the social and behavioral factors impacting health that are more significant than simply assuring access.
- Assuming all have a right to basic health care, what is included in this right?
- Are there limits?

Ethical Discernment

- How do we as individual health care professionals, mission leaders, administrators, or as decision-makers in our other roles in Catholic Health Care reconcile our mission to serve both the common good and the poor and vulnerable with the reality of limited resources which require health care resource allocation decisions to be made?

Is it Ethical....

- Does Catholic Social Teaching allow for, or support, systemic health care resource allocation decisions that ultimately may limit access of health care resources to individuals or groups of individuals who are considered part of a vulnerable population?

**Four Questions:
How to Answer From a CST perspective**

- 1. Why should improving the condition of vulnerable populations receive priority?
- 2. Of the vulnerable populations we have identified, who are the worse-off for the purposes of health resource prioritization?
- 3. Should absolute priority be given to the worse-off of the vulnerable populations identified?
- 4. If not, how much priority should the worst-off vulnerable populations be given?

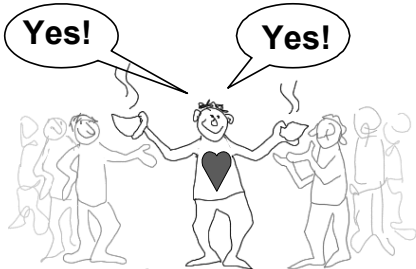
(Modified questions from Brock, 2002: 285 in Ethical Dimension of Health Policy, Eds.-- M. Danis, C. Clancy, and L. Churchill).

- How do we ethically discern the allocation of health care resources that we know will impact vulnerable individuals, groups of individuals, or populations?

•BECAUSE.....

We want to be able to provide to all:

- The best of care available
- Equal care
- Physician and Patient Choice
- **And** do all this while containing costs



Benevolence

Benevolence knows no limits,
excludes no one, embraces all
goodness (Glaser, 1994)

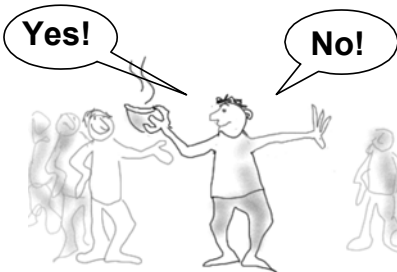
Benevolence

- universal
- comprehensive
- without limits
- timeless
- immediate
- affective (Glaser, 1994)

HOWEVER...

We must set limits....

- The need for health care services competes with society's need for housing, security/safety, transportation, and education
- We must accept inequalities in the provision of health care services. It is not possible to provide all with the health care services they want.
- We must limit choices.



Beneficence

Always faces limits, meets boundaries, trades off one set of values to realize another set of values
(Glaser, 1994).

Beneficence

- particular
- partial
- within limits
- time-bound
- delayed
- effective (Glaser, 1994)



Every
YES
to dignity
is a hard
choice--it
involves
1000
NOs. . . .
to
dignity.

Good Ethical Decisions always result in consequences that are positive and negative



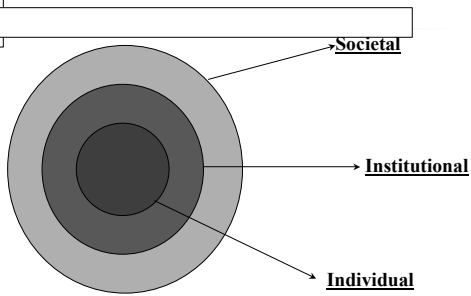
- cause pain
- demand sacrifice
- neglect need
- withhold resources
- increase burdens
- give pleasure
- bestow benefit
- respond to need
- provide resources
- lighten burdens

Three Realms of Ethics

- Individual
- Institutional
- Societal

• (Glaser, 1994)

Three Realms



(Glaser, 1994)

Ethical Discernment Process

- Be “transparent, accountable and principled” in the rationing of health care resources (Glaser, 2007: 4)
- Establish health care as a basic good
- Engage the communities of concern
- Work to serve the common good and not individual self interest.
- Collaborate with local community resources
- Engage governmental agencies (principle of subsidiarity)
- Identify the essential elements, priorities, and limits of health care services

Procedural Justice

- Encourages careful deliberation
- Explanations for decisions
- Opportunities for questioning decisions
- Correction of inevitable errors of judgment (Mechanic, 2003: 19)

It is an illusion to believe that we can avoid muddling through to some extent. The hope is that we can do so thoughtfully (David Mechanic 2003:19).

QUESTIONS?

COMMENTS?
