

**Re-Imagining Health Care: Effective Altruism and Beyond**  
**GHHP 80 – SPRING 2017**  
Wednesdays, 1-3p  
Sever 111

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**Prerequisites**

*None*

**Instructional Staff**

There is no TF for this course. Please reach out to me directly. Office hours are held by appointment.

**Course Description**

Real-world health systems are a mess. They stem from the successful or failed efforts of multiple constituencies with different medical, political, and economic priorities over many years. But what does an ethical health system aspire to achieve in the first place? Does it, for example, seek only to reduce premature death and disability, or also to distribute these burdens more equally? Does it make economic calculations, or emphatically reject putting a dollar sign over human lives? When resources are scarce, does a fair system prioritize patients in the prime of their lives over ones who have already had their fair share of life years? Should extra priority go to those who have suffered from severe disability for years, current practice notwithstanding?

Students in this seminar will re-think what a health system should try to achieve. The seminar will start with a practical decision: an independent donor has offered your group \$25,000 for charity, and you will debate over two sessions which charity will receive it. To reach a decision, you will evaluate arguments for and against effective altruism. The seminar will then build on these insights to tackle, over ten sessions, a larger question: What are the philosophical contours of an ideal health system? A final meeting will examine how this characterization of ethical health systems may have changed your minds about what charity to support. You will then select the winning charity.

## Course Aims and Objectives

The overarching aim of this course is to identify and debate fundamental ethical considerations surrounding the allocation of aid and of health resources.

By the end of this course, students should be able to:

- Recognize central ethical considerations in charitable donation and health resource prioritization
- Understand central arguments for positions on these considerations
- Develop preliminary capacity for critically assessing theories in normative health policy

## Course Policies and Expectations

Please note that this syllabus may change (with ample warning) as the course develops and students provide midterm evaluations.

Cell phone use, emailing, social media sites, and irrelevant browsing are forbidden during our group discussions.

Class attendance is mandatory and will be reflected in the course grade, but each student gets 1 session off, no questions asked. For anything beyond that, you must contact the instructor in advance. *Ditto* for arriving late or leaving early.

Class will start strictly at 1:07pm. Please arrive a few minutes before in order to settle in.

## Materials and Access

All course readings will be available on the course website. Buy only books that you find interesting and wish to do more than the assigned reading in.

## Assignments and Grading Procedures

The grade for this course is cardinal (there is no pass/fail option). Here is a breakdown of the course requirements and the weight given to each in determining your course grade:

Assignment	Weight
Class Participation	15%
Discussion Board Responses	10%
Charity Exercise	5%
Case Presentation	15%
Final Paper Outline	20%
Final Paper	35%

## **Class Participation**

This is a discussion-based seminar. I will keep my lecturing to a minimum, and all of us will benefit if everyone is engaged, and makes interesting comments. Please plan to come to every class fully prepared—that means having done all of the reading and written down some points for yourself—and to actively and thoughtfully participate in discussion.

The class participation component of the course grade will be calculated as follows. For each class you will receive 1 point for being there and having done the reading, and 1 point for contributing. You get an extra ½ point for saying something great (in addition to whatever you earn by showing up and speaking). Classes permissibly missed will not adversely affect your grade.

## **Discussion Board Posts**

Each week, students will be asked to post reflections of up to 250 words on the *Canvas* discussion board by 2pm on Tuesday before class. This exercise is intended to start the class dialogue and tee up questions raised by the material.

Toward class and following it, students will be welcome to return to the discussion board to continue the conversation. Doing so will earn you extra credit on your discussion board grade (in addition to whatever you earn by posting on a timely basis prior to class) but is not required.

There will be a separate thread in our discussion board for “miscellaneous” material that is related to our course themes but not directly to any particular readings. Making this a lively space for discussion outside of class will also help your participation grade and is not required.

## **Charity Exercise**

In preparation for Week 2, each student should prepare a 3-minute comment on which charity we should channel the \$25,000 amount to, and why. After Week 2 class, each student should post on the *Canvas* discussion board a brief reflection (~250 words) that describes whether they were convinced by other students – and if not, why not.

## **Case Presentation**

Prior to Week 2 class, each of you will pick a case on *Canvas* and, on the relevant week, present it to the group. You will relay the dilemma lucidly and vividly, and defend a position on this dilemma that you either believe in or not. Your peers will then play devil’s advocates and you will answer some of their challenges to the position you defended. You can use special formats, voting, costumes, or whatever else it takes to keep this fun. The entire discussion should take 15 minutes.

## Final paper outline

The (required and graded) final paper outline is an opportunity for students to develop and receive feedback from me on their topic and on a skeleton-version of their argument. The document should be organized as a 1-2 sentence statement of your thesis followed by a numbered outline (1, 1.1, 1.1.1, 1.1.2, 1.2, 1.3, 2, 2.1,...), wherein you identify your arguments in support of your thesis, the counter-arguments you will consider, and your counters to the counters. The outline should be no longer than a single page and should be submitted via *Canvas* by **11:59p on March 22**. I will aim to have feedback for you by the following week, leaving you just about a month to draft the full paper. Feel free to reach out if you have questions about your topic or this assignment prior to the due date.

*Prior* to writing the outline, you must obtain my approval for your topic. Please suggest a topic by **11:59p on February 16**, by uploading to *Canvas* a question (or topic) that you are considering, and 3-5 sentences to clarify what you mean and its relevance to the course (this is not graded but mandatory for writing a final paper outline, and the final paper itself).

## Final paper

The final paper is an opportunity for students to explore a topic of their choosing related to charity choice, health service delivery, or population health improvement. The topic may be drawn from course materials, from the press, or from your personal experiences. A strong paper would model itself after our case discussions in class inasmuch as it presents a dilemma and outlines positions for and against potential strategies. The final term paper should be no longer than 1300 words. It should be submitted via *Canvas* by **11:59p on April 30**.

## Academic Integrity

Discussion and the exchange of ideas are essential to academic work. For assignments in this course, you are encouraged to consult with your classmates on the choice of paper topics and to share sources. You may find it useful to discuss your chosen topic with your peers, particularly if you are working on the same topic as they. However, **you should ensure that any written work you submit for evaluation is the result of your own research and writing only and that it reflects your own approach to the topic.** You must also adhere to standard citation practices and properly cite any books, articles, websites, lectures, etc. that have helped you with your work. If you received any help with your writing (feedback on drafts, etc.), you must also acknowledge this assistance.

Occasional collaboration on discussion board contributions and any voluntarily-taken assignments is encouraged, with proper acknowledgement, and will not affect grades. Final papers and case presentations will usually be single-authored. If you wish to collaborate on them please contact me in advance to explain why.

For further details please see Harvard's [Honor Code website](#).

**Accommodations for students with disabilities**

Students needing academic adjustments or accommodations because of a documented disability must present their Faculty Letter from the Accessible Education Office (AEO) and speak with the instructor by the end of the second week of the term (Feb 1, 2017). It is University policy that failure to do so may result in the course head's inability to respond in a timely manner. All discussions will remain confidential, although I may contact AEO to discuss appropriate implementation.

## Course Schedule

Module	Week	Date	Topic
Charity choice	<i>Week 1</i>	January 25	<b>Course overview + Introduction of the charity exercise</b>
	<i>Week 2</i>	February 1	<b>Charity exercise</b>
Health resource distribution: Patterns	<i>Week 3</i>	February 8	<b>Pattern vs currency + Maximum vs equality</b> <ul style="list-style-type: none"> <li>Case: Building a hypertension clinic</li> </ul>
	<i>Week 4</i>	February 15	<b>Intergroup equality vs inter-individual equality</b> <ul style="list-style-type: none"> <li>Case: The World Health Report 2000 controversy</li> </ul>
	<i>Week 5</i>	February 22	<b>Equality vs priority</b> <ul style="list-style-type: none"> <li>Case: Solicited organ donation</li> </ul>
	<i>Week 6</i>	March 1	<b>Equality vs sufficiency</b> <ul style="list-style-type: none"> <li>Case: Reading glasses and eye surgeries</li> </ul>
	<i>Week 7</i>	March 8	<b>Distribution vs recognition + Midterm evaluations</b> <ul style="list-style-type: none"> <li>Case: US Blood donation from men who have sex w men</li> </ul>
<i>Week 8 SPRING BREAK</i>			
Health resource distribution: currencies	<i>Week 9</i>	March 22	<b>Outcomes vs access</b> <ul style="list-style-type: none"> <li>Case: Past alcoholism and the liver transplant list</li> </ul>
	<i>Week 10</i>	March 29	<b>Realizations vs chances</b> <ul style="list-style-type: none"> <li>Case: Coverage of prevention only in HIV</li> </ul>
	<i>Week 11</i>	April 5	<b>Lifetime vs snapshot + Age-weighting vs age-blindness</b> <ul style="list-style-type: none"> <li>Case: <i>Oseltamivir</i> allocation in avian flu in Boston</li> </ul>
	<i>Week 12</i>	April 12	<b>Strictly health vs everything</b> <ul style="list-style-type: none"> <li>Case: Deworming and future productivity</li> <li><i>Guest speaker: Zach Ward, MPH</i></li> </ul>
Charity choice continued	<i>Week 13</i>	April 19	<b>Wrap up of patterns and currencies in health policy + Discussion of select term papers</b>
	<i>Week 14</i>	April 26	<b>Charity exercise revisited</b> <ul style="list-style-type: none"> <li><i>Guest speaker: Michael Kremer, PhD</i></li> </ul>

## Course Reading Schedule

Week 1 - January 25: Course overview + Introduction of the charity exercise

*This session will relay the term plan and clarify our job of picking a charity to win \$25,000 from [The Philanthropy Lab](#).*

No reading or case

Week 2 - February 1: Charity exercise

*Prior to class this week, please fill out [this pre-course survey](#) from the Philanthropy Lab. It will not be graded but is required. The survey can also be found under Assignments on Canvas.*

*In this session students will each make the initial case for choosing a certain charity to receive \$25,000. We will introduce and start debating the idea of effective altruism.*

- (1) [Singer, Peter. \*The Why and How of Effective Altruism\*](#). TED Talk. Accessed January 5, 2017. **Popular introduction to effective altruism.**
- (2) Center for Effective Altruism. "[Introduction to Effective Altruism](#)." EffectiveAltruism.org. Accessed January 5, 2017. **Basic introduction to effective altruism.**
- (3) Wiblin, Robert. "[Philosophical Critiques of Effective Altruism by Prof Jeff McMahan](#)." Effect-altruism.com. *Effective Altruism Forum*, May 3, 2016. **Presentation of and response to ethical critiques of effective altruism.**

### Optional

- (4) Srinivasan, Amia. "[Stop the Robot Apocalypse](#)." Review of *Doing Good Better: Effective Altruism and a Radical New Way to Make a Difference*, by William MacAskill. *London Review of Books* 37 no. 18 (2015): 3-6. **An ethical critique of effective altruism.**

No case

Week 3 - February 8: Pattern vs currency + Maximum vs equality

*This session moves to health resource prioritization and introduces the distinction (from Gerald Cohen's article for week 9) between distributive patterns and distributive currencies. It also asks whether health policy should seek to maximize things like health or welfare, or instead seek also to equalize them in the population.*

- (1) Brock, Dan W. (2007). "Health care resource prioritization and rationing: why is it so difficult?" *Social Research* 74, no. 1 2007: 125-148. **Shows the need for health resource prioritization.**
- (1) Woodward, A., and I. Kawachi. "Why Reduce Health Inequalities?" *Journal of Epidemiology and Community Health* 54, no. 12 (2000): 923–29. **Makes the case for equality in health resource distribution.**
- (2) Temkin, Larry. "Inequality and Health." In *Inequalities and Health: Concepts, Measures and Ethics*. New York: Oxford University Press, 2013. **Makes the case for equality in general, with some emphasis on health resource distribution.**
- (3) Ord, Toby. "[The Moral Imperative towards Cost-Effectiveness in Global Health.](#)" *Center for Global Development Essays*, March 2013. **Argues for strict maximizing in some health resource prioritization dilemmas.**

#### Optional

- (4) Brock, Dan W. "Priority to the Worse Off in Health Care Prioritization." In *Medicine and Social Justice: Essays on the Distribution of Health Care*, 362–72. New York: Oxford University Press, 2002. **Propagates some weight for priority to the worse off in health resource distribution.**

#### Case: Building a hypertension clinic

This simplified case is presented in the clip at: <https://vimeo.com/85057796>. The relevant bit starts at 4:30. Please prepare to show the clip and add factual background and insights from the reading, as well as an outline of arguments for and against the more egalitarian choices in this case. Please mention but go beyond factual claims about the impact of social inequalities.

**Case reading:** Marmot, Michael. "Fair Society Healthy Lives." In *Inequalities in Health: Concepts, Measures and Ethics*, edited by Nir Eyal, Ole Norheim, Samia Hurst and Dan Wikler, 282–99. Population-Level Bioethics. New York: Oxford University Press, 2013.

#### Week 4 - February 15: Intergroup equality vs inter-individual equality

*In this session we debate whether the inequalities that egalitarians should focus on are ones between individuals or ones between certain population groups. We also take time to offer feedback on the course and how to improve its second half.*

- (1) Whitehead, M. "The Concepts and Principles of Equity and Health." *International Journal of Health Services: Planning, Administration, Evaluation* 22, no. 3 (1992): 429–45. **Classical defense of focus on equality between population groups.**
- (2) Eyal, Nir. "Inequality in Political Philosophy and in Epidemiology: A Remarriage." *Journal of Applied Philosophy*, 2015. **Recent defense of focus on equality between individuals.**

### Optional

- (3) Hausman, Daniel, and Matt Waldren. "Egalitarianism Reconsidered." *Journal of Moral Philosophy* 8, no. 4 (2011): 567–86. **Complex position on egalitarian focus on groups vs on individuals.**
- (4) Lippert-Rasmussen, Kasper. "When Group Measures of Health Should Matter." In *Inequalities in Health: Concepts, Measures and Ethics*, 52–66. Population-Level Bioethics. New York: Oxford University Press, 2013. **A defense of egalitarian focus on equality between individuals.**
- (5) Young, Iris Marion. "Equality of Whom? Social Groups and Judgments of Injustice." *Journal of Political Philosophy* 9, no. 1 (2001): 1-18. **Powerful defense of focus on equality between population groups.**

### Case: The controversy about World Health Report 2000

World Health Report 2000 was innovative in assessing health inequalities, not between advantaged and disadvantaged patient populations but between individual patients. Was that approach right?

**Case reading:** Braveman et al (2001). "World Health Report 2000: how it removes equity from the agenda for public health monitoring and policy." *British Medical Journal* 323, no. 7314: 678-81.

### Week 5 - February 22: Equality vs priority

*In this session we focus on the critique of egalitarianism by recently-deceased great philosopher Derek Parfit, and on his alternative to egalitarianism, namely, the priority view, according to which what matters is the absolute position of the worse off, not the gap between them and others.*

- (1) Parfit, Derek. *Equality or Priority?* The Lindley Lectures. University of Kansas, 1991. **The case for prioritarianism.**
- (2) Otsuka, Michael, and Alex Voorhoeve. "Why It Matters That Some Are Worse Off Than Others: An Argument against the Priority View." *Philosophy & Public Affairs* 37, no. 2 (2009): 171–99. **A case against prioritarianism.**

### Optional

- (3) Eyal, Nir. "Leveling Down Health." In *Inequalities in Health: Concepts, Measures and Ethics*, edited by Nir Eyal, Ole Norheim, Samia Hurst and Dan Wikler, 194-213. New York: Oxford University Press, 2013. **A defense of egalitarianism.**

### Case: Solicited organ donation

Not all patients with acute organ failure are high on the organ waitlist. Some who are not circumvent the waitlist system by soliciting organ donations earmarked specifically for them.

While these donations do not usually come from the general organ pool, and thus do not directly reduce organ availability for those higher on the list, some have argued that they are unfair. Would forbidding these so-called “solicited organ donations” be what Derek Parfit calls “leveling down”? And if so, is it nonsensical to say that there is something unfair about them?

**Case reading:** Caplan, Arthur. “Organs.com: New Commercially Brokered Organ Transfers Raise Questions.” *The Hastings Center Report* 34, no. 6 (2004): 8.

## Week 6 - March 1: Equality vs sufficiency

*In this session we discuss another critique of egalitarianism, called the sufficiency view. According to that view, what matters is that everyone have enough, not the gap between them.*

- (1) Frankfurt, Harry. “Equality as a Moral Ideal.” *Ethics* 98, no. 1 (1987): 28–43. **A classical exposition of sufficientarianism.**
- (2) Fourie, Carina, and Annette Rid. “Introduction.” In their (edited) *What Is Enough? Sufficiency, Justice and Health*, 2016. (Note: Focus on the opening pages.) **A recent suggestion that sufficientarianism may be very relevant to health resource distribution.**
- (3) Casal, Paula. “Why Sufficiency Is Not Enough.” *Ethics* 117, no. 2 (2007): 296–326. **A critique of sufficientarianism.**

### Optional

- (4) Crisp, Roger. “Equality, Priority, and Compassion.” *Ethics* 113, no. 4 (2003): 745–63. **A defense of sufficientarianism.**
- (5) Temkin, Larry. “Egalitarianism Defended.” *Ethics* 113, no. 4 (2003): 764–82. **An egalitarian response to the latter and an excellent exposition of egalitarianism.**
- (6) Crisp, Roger. “Egalitarianism and Compassion.” *Ethics* 114, no. 1 (2003): 119–26. **A response to this response.**

### Case: Reading glasses and eye surgeries

Eye care missions to low-income countries have become a popular form of global health service (e.g. Unite for Sight). In planning for such a trip, a group of doctors estimate that they will meet 100 people with age-related nearsightedness of varying severities. The doctors could bring 100 pairs of donated eyeglasses with them to distribute, which would help slightly-nearsighted patients (who already see at a level that is well above what is “good enough”) see 20/20. Alternatively, the doctors could use their funds to arrange for surgical interventions on those people whose vision is poorest. This would mean that 10 people with near-blindness (let us assume that this is not “good enough”) get surgery that enables them to see just a little better, and perform tasks like and reading with extreme difficulty (assume that this is “just enough”), yet others get nothing. Which approach would you recommend, and is that compatible with sufficientarianism, egalitarianism, and utilitarianism?

**Case reading:** Segall, Shlomi. “What Is the Point of Sufficiency?” *Journal of Applied Philosophy* 33, no. 1 (2016): 36–52.

#### Week 7 - March 8: Distribution vs recognition + Midterm evaluations

*In this session we assess the view that focus on distribution misses the point, and that instead we should be thinking of parity of status.*

- (1) Anderson, Elizabeth S. “What Is the Point of Equality?” *Ethics* 109, no. 2 (1999): 287–337. **A fierce attack on the focus on distributive equality.**
- (2) Fraser, Nancy. “Recognition without Ethics?” *Theory, Culture & Society* 18, no. 2–3 (2001): 21–42. **A proposal for an expanded concept of justice that includes both social equality and recognition of difference.**

#### Optional

- (1) Arneson, Richard J. “Luck Egalitarianism and Prioritarianism.” *Ethics* 110, no. 2 (2000): 339–49. **A defense of focus on distribution.**

#### Case: Blood donation from men who have sex with men in the US

Thanks in part to commentaries like Cohen’s (below), the FDA recently reviewed the blood donation policy related to blood donation among men who have sex with men (MSM). On Dec. 21, 2015, the FDA [switched](#) its original 1985 blood donation policy for MSM from an outright ban to a one-year deferral since last sexual contact. Given Cohen’s argument, is the current policy just or should we go further in relaxing barriers related to MSM donation? To what extent was the US ever justified in rejecting blood donations from men who had sex with men?

**Case reading:** Cohen, I. Glenn, Jeremy Feigenbaum, and Eli Y. Adashi. “Reconsideration of the Lifetime Ban on Blood Donation by Men Who Have Sex With Men.” *JAMA* 312, no. 4 (July 23, 2014): 337–38.

#### Week 8 - March 15: NO CLASS – SPRING BREAK

#### Week 9 - March 22: Outcomes vs access

*In this session we start turning our attention to the so-called “currency” of what is being distributed. We focus specifically on “currencies” with an element of personal responsibility for disadvantage.*

- (1) Cohen, Gerald. “On the Currency of Egalitarian Justice.” *Ethics* 99, no. 4 (1989): 906–44. **Makes the distinction between pattern and currency and recommends the currency of access to advantage.**

- (2) Wikler, Dan. "Personal and Social Responsibility for Health." In *Public Health, Ethics and Equity*, 109–35. Oxford University Press, 2004. **Argues against currencies focused on personal responsibility, at least in the health arena.**

Optional

- (3) Roemer, John. "Equality of Opportunity: An Example." In *Theories of Distributive Justice*, 276–79. Cambridge, MA: Harvard University Press, 1996. **Suggests a way to couple fundamental focus on personal responsibility for risks taken with sensitivity to the social gradient of choices to take risks.**

**Case: Past alcoholism and the liver transplant list**

Do you approve of the proposal by Siegler and Moss (below)?

**Case reading:** Moss, A. H., and M. Siegler. "Should Alcoholics Compete Equally for Liver Transplantation?" *JAMA* 265, no. 10 (1991): 1295–98.

**Week 10 - March 29: Realizations vs chances**

*In this session we debate whether the relevant distributive currency should be in terms of personal outcomes or, alternatively, in terms of the chances or prospects for such outcomes.*

- (1) Daniels, Norman. "Can There Be Moral Force to Favoring an Identified over a Statistical Life? - Oxford Scholarship." In *Identified versus Statistical Lives: An Interdisciplinary Perspective*. Oxford University Press, 2015. **Defends focus on chances.**
- (2) Eyal, MS. "Against fair chances: two draft arguments." Unpublished manuscript. **Argues against focus on chances.**

Optional

- (3) Stefánsson, H. Orri. "Fair Chance and Modal Consequentialism." *Economics and Philosophy* 31, no. 3 (2015): 371–395. **An excellent recent defense of focus on chances.**

**Case: Coverage of prevention-only in HIV**

If a certain countermeasure against HIV is more cost-effective than any form of treatment (which may be the case for male circumcision), should health ministries and donors in resource-constrained countries use HIV budgets to fund only that form of prevention, until a point when funding it is as cost effective as other countermeasures, including treatment? Should they maintain this approach even though it could mean that infected patients are denied life-saving antiretroviral medications?

**Case reading:** Frick, Johann. "Treatment versus Prevention in the Fight against HIV/AIDS and the Problem of Identified versus Statistical Lives." In *Identified versus Statistical Lives: An*

*Interdisciplinary Perspective*, edited by Glenn Cohen, Nir Eyal, and Norman Daniels, 182-202. Oxford University Press, 2015.

#### Week 11 - April 5: Lifetime vs snapshot + Age-weighting vs age-blindness

*In this session we focus on time. We ask, specifically, whether doctors and health systems should part ways with current practice and prioritize partly based on patients' past conditions; and whether and how they should assign patients priority for intervention in accordance with their age.*

- (1) Ottersen, Trygve, Ottar Mæstad, and Ole Frithjof Norheim. "Lifetime QALY Prioritarianism in Priority Setting: Quantification of the Inherent Trade-Off." *Cost Effectiveness and Resource Allocation: C/E* 12, no. 1 (2014): 2. **Defends a focus on lifetime health, including past morbidities.**
- (2) McKerlie, Dennis. "Equality and Time." *Ethics* 99, no. 3 (1989): 475–91. **Defends a focus on contemporaneous comparisons, not lifetime comparison.**
- (3) Persad, Govind, Alan Wertheimer, and Ezekiel J. Emanuel. "Principles for Allocation of Scarce Medical Interventions." *Lancet (London, England)* 373, no. 9661 (2009): 423–31. **Defends priority to the young, but not to the youngest.**

#### Optional

*Note: The articles below are reactions to the Persad et al, 2009 Lancet piece (above) in the American Journal of Bioethics (AJOB). The first two pieces are responses by Kerstein and Bognar and Paul Menzel. Persad et al then replied in AJOB. Finally, Kerstein and Bognar aimed to respond to the response and summarize parts of the debate.*

- (4) Kerstein, Samuel J., and Greg Bognar. "Complete Lives in the Balance." *The American Journal of Bioethics: AJOB* 10, no. 4 (2010): 37–45.
- (5) Menzel, Paul T. "Complete Lives, Short Lives, and the Challenge of Legitimacy." *The American Journal of Bioethics: AJOB* 10, no. 4 (2010): 50–52.
- (6) Persad, Govind C., Alan Wertheimer, and Ezekiel J. Emanuel. "Standing by Our Principles: Meaningful Guidance, Moral Foundations, and Multi-Principle Methodology in Medical Scarcity." *The American Journal of Bioethics: AJOB* 10, no. 4 (2010): 46–48.
- (7) Kerstein, Samuel J., and Greg Bognar "Response to Open Peer Commentaries on 'Complete Lives in the Balance.'" *The American Journal of Bioethics: AJOB* 10, no. 4 (2010): W3-5.

#### Case: *Oseltamivir* allocation during avian flu pandemic in Boston

Imagine that for the past several months, there has been sustained human-to-human transmission of a novel strain of avian *influenza A* with genetic components of human influenza in several countries around the world. Boston was first affected three weeks ago, and since then there have been over 500 cases and 50 deaths. *Oseltamivirphosphate* (= "*oseltamivir*", "*Tamiflu*") is the only drug that may effectively reduce mortality of infected patients and limit infection of

exposed persons. However, supplies of oseltamivir are limited, and in Boston, 3 hospitals use a different protocol each for prioritizing access to oseltamivir:

- In order to maximize survival rates, **Hospital 1** has decided to reserve its remaining cache of oseltamivir for treatment of the patients most likely to benefit (namely those who present within 48 hours of disease onset)—as well as to staff and their families so that staff will continue to show up to work despite the risk of infection.
- Recognizing that it is impossible to treat all presenting patients, **Hospital 2** has decided to give priority to probable and confirmed cases in younger patients, primarily on the ground that younger patients will have had fewer years of life than older patients should they die of the disease.
- In an effort to save its very ill patients, **Hospital 3** reserves its remaining cache of oseltamivir for treatment of the sickest influenza patients without age discrimination. To protect its staff, it is relying on airborne infection isolation and personal protective equipment (namely N-95 respirators, gloves, and gowns): oseltamivir is not used for prophylaxis.

Which hospital has the best protocol? Which has the fairest one?

**Case reading:** Emanuel, Ezekiel J., and Alan Wertheimer. “Who Should Get Influenza Vaccine When Not All Can?” *Science* 312, no. 5775 (May 12, 2006): 854–55.

Week 12 - April 12: Strictly health vs everything

*In this session we discuss how isolated decision making in the health ministry should be from that in other ministries. Should the health system focus only on medical care, or also on social determinants of health? And should health resource rationing serve non-health social goals.*

We will be joined by guest speaker **Zach Ward, MPH** is a doctoral student with Harvard’s PhD in Health Policy and Analyst at the Center for Health Decision Science.

- (1) Daniels, Noman. “When Are Health Inequalities Unjust? The Social Determinants of Health.” In *Just Health: Meeting Health Needs Fairly*, 79–102. New York: Cambridge University Press, 2008. **Defends focus on social determinants.**
- (2) Segall, Shlomi. “Is Health Care (Still) Special?” *Journal of Political Philosophy* 15, no. 3 (2007): 342–61. **A response to Daniels.**
- (3) Christakis, Nicholas A. “Social Networks and Collateral Health Effects.” *BMJ* 329, no. 7459 (2004): 184–85. **Propagates taking non-health effects into account in health resource prioritization.**
- (4) Brock, Dan W. “Separate Spheres and Indirect Benefits.” *Cost Effectiveness and Resource Allocation : C/E* 1 (2003): 4. **Defends ignoring non-health effects in some areas not all.**

### Case: Deworming and future productivity

Deworming is a popular public health program that involves treating people at risk of intestinal parasitic worm infections with parasite-killing drugs. Mass treatment is very inexpensive (in the range of [\\$0.50-\\$1 per person treated](#)). Deworming has become a favorite cause of effective altruist organizations (such as *GiveWell*) mainly due to evidence that the relatively low-cost intervention can produce positive impacts on test scores and income later in life ([see here for an example](#)). Malaria remains a persistent global health threat, claiming the lives of more than 400,000 people in 2016. Treatment for malaria can cost as little as [27 cents per dose of quinine](#) in much of the developing world. Nevertheless, many people simply recover from malaria without drug treatment and others harbor the disease for months or years with little to no long term consequences. Given these numbers, and any additional ones that you can find on the *GiveWell* website and may consider more pertinent, should the non-health, long-term impacts of deworming be considered in “competition” against funding fuller malaria response?

**Case reading:** Miguel, Edward, and Michael Kremer. “Worms: Identifying Impacts on Education and Health in the Presence of Treatment Externalities.” *Econometrica*; *Evanston* 72, no. 1 (2004): 159–217. (Note: This classical article has been questioned recently. Please use discussions of it and of the organizations like AMF and Deworm the World on GiveWell.org. Please do *not* focus primarily on the validity of the article’s findings.)

Week 13 - April 19: Wrap up of patterns and currencies in health policy + Discussion of select term papers and summary

*In this session we both summarize and feature select students’ term paper drafts.*

- (1) Norheim, Ole F., Rob Baltussen, Mira Johri, Dan Chisholm, Erik Nord, Dan W Brock, Per Carlson, et al. “Guidance on Priority Setting in Health Care (GPS-Health): The Inclusion of Equity Criteria Not Captured by Cost-Effectiveness Analysis.” *Cost Effectiveness and Resource Allocation*: *C/E* 12 (2014): 18. **A WHO-group’s suggestion of considerations to complement cost effectiveness for policy makers.**

No case

Week 14 - April 26: Charity exercise revisited

*In this session we determine which charity will receive the \$25,000 award.*

Guest speaker, **Michael Kremer, PhD**, the Gates Professor of Developing Societies in the Department of Economics at Harvard University, will join us for the first part of today’s class.

- (1) Gabriel, Iason. “Effective Altruism and Its Critics.” *Journal of Applied Philosophy*, February 1, 2016. **A recent defense of effective altruism from many criticisms.**

- (2) Brock, Dan, Norman Daniels, Peter Neumann, and Joanna Siegel. “Ethical and Distributive Considerations.” In *Cost-Effectiveness in Health and Medicine*, Second Edition., 319–43. New York: Oxford University Press, 2017. **A recent summary of ethical issues beyond cost effectiveness in health resource distribution (and potentially in charity choice).**

Optional

- (3) Clough, Emily. “[Effective Altruism’s Political Blind Spot](#).” *Boston Review* July 14, 2015. **An economic critique of effective altruism. See [response](#).**

No case