POLICY REPORT

Healthcare Systems:

A Political and Philosophical Analysis

Introduction

In Warwick Think Tank's first report, we will be answering key questions posed to the state of healthcare.

We have chosen to defend universal healthcare, by examining the limitations of the Hippocratic Oath in the modern era and looking into the disparities in healthcare provision between migrants and nationals (Bahrain: Case Study).

1) The Hippocratic Oath and Modern Healthcare Systems: Can the Physician Deliver on The Promises of the Oath?

2) Healthcare disparities between labourers and citizens – why does this matter?

We conclude the report by making recommendations that the healthcare system should adopt, in response to the Coronavirus pandemic and to strengthen the public healthcare for future threats.

The Hippocratic Oath and Modern Healthcare Systems: Can the Physician Deliver on The Promises of the Oath?

On April 28 2018, a viral video of Rebecca Hall, a 22-yr-old psychiatric patient who was thrown out from hospital and onto the street, began circulating around the internet. The University of Maryland Medical Centre maintained that the situation occurred due to a “breakdown in coordination” (Moyer, 2018), but others disagreed. Protestors claimed that this was just another example of ‘patient dumping’, an unethical practice whereby patients that are deemed difficult to treat, or appear to be uninsured are simply gotten rid of (ibid). Though it is unethical, the practice is not illegal.

This is just one instance, but occurrences of patients being denied necessary healthcare are increasingly widespread. In the US, 1 in 4 insurance claims made by patients with chronic illnesses are rejected (Schoen, 2017). Consequently, patients will either leave hospital not having received the appropriate care they deserve, or with loans that may drive them to the point of bankruptcy (Sainato, 2019). Such instances raise concerns about the integrity and duty of professionals within healthcare systems. Questions such as: why are the systems they operate within designed in direct contention with the vows they undertake upon entering the noble profession?

The vow in question, The Hippocratic Oath, is a widely known oath taken by medical students upon completion of their studies. Having been in existence since 400BC, the vow is regarded as the gold standard of professional ethical standards in medicine. Despite being rejected by the US Supreme Court as a concrete guide to medical ethics in 1973, the oath (and in some cases a modified version of it) is administered by more than half of the medical schools in the US upon graduation (Indla and Radhika, 2019). Through each revision, the oath has maintained its classical triadic structure: tying together the patient, physician and illness (ibid).

This structure served well for times in which the oath was crafted. Around the time of creation, a significant number of physicians ascribed to Neo-Pythagoreanism, and so their strong sense of morality and ethical principles was evident in the original oath (Jotterand, 2005). Working very independently, they were able to truly take responsibility for honouring the oath.

However, in the last several centuries, the power structures of medical systems have changed drastically. As such, the oath can be argued as lacking the necessary directives to guide medical professionals in the present climate.

The Hippocratic Oath has lost its ability to effectively guide, and has become merely symbolic. Deans of medical schools across the UK have acknowledged that the oath is primarily used to signify someone moving from being a student to a practitioner (or a graduate), rather than having moral bearing (Green, 2017).

This view is unavoidable, especially when patients like Rebecca Hall are dumped onto the streets by professionals who have sworn an oath to protect the sick and vulnerable? Now, more than ever, the necessary questions regarding the sanctity of healthcare provision need to be aimed at healthcare systems, and the institutions that govern them (Walton and Kerridge, 2014).

The original oath is more focused on the physician, and the medical community, under the assumption that physicians are following no other set of rules. In light of the commercialized nature of current healthcare, the physician is bound by a more pressing set of constraints. Whereas once healing was an artform, it is now little more than a service to be rendered (Indla and Radhika, 2019). Modern medicine has redefined the boundaries of being a 'patient', becoming more exclusionary, rather than inclusive. As exemplified in the case of Rebecca Hall, an illness is not enough to qualify one as a patient - now, whether or not treatment is in the hospital's financial interests is also a crucial characteristic

It might seem as though the Hippocratic Oath is rendered useless only in the context of privatised healthcare. However, the criticism applies to nationalised healthcare systems too - such as in the UK and Cuba. The healthcare systems in both these countries are publicly funded, but political whims can dictate government spending (King's Fund, 2019) or guidelines (Warner, 2016), in turn severely limiting the physician's ability to deliver on their promises.

<u>Conclusion</u>

Since the 5th century BC, systems of healthcare provision have undergone a great upheaval, but the Hippocratic Oath has remained. Given its ineffectiveness in both private and public healthcare systems, it is arguably an outdated description of healthcare standards. There is no meaning to its focus on humility and compassion of the physician when governments and/or private companies in the health industry have no incentive to allow the physician to deliver quality patient care, in favour of cutting costs and maximising profit margins.

As it stands, the Hippocratic Oath does not challenge the barriers between optimal patient and physician, varied as they are in modern healthcare systems. The revisions of the Hippocratic Oath that have taken place so far have been necessary - crucially, removing the restraint on assisted suicide and abortion. However, the current bounds of healthcare that need to be challenged are not within the current Hippocratic Oath.

Perhaps, a revision of the Hippocratic Oath is needed: to truly widen the healthcare discourse, moving away from the notion of the independent physician to the physician operating within a

healthcare system. It would invigorate the vows. And, most importantly, it would prompt much needed reforms, that give greater power to healthcare professionals to truly prioritise quality patient care.

Healthcare disparities between labourers and citizens – why does this matter?

Bahrain: a case study

The kingdom of Bahrain is an island group located off the central shores of the Arabian Gulf - its name derives from the Arabic term *al- bahrayn*, meaning “two seas.” In order to understand the nature of healthcare, other social parameters must be explored in order to provide context. As of 2018, Bahrain’s adult literacy rate has stood at an impressive 97.5 percent - a testament to their efforts in implementing universal primary education. Women make up twenty-five to thirty percent of the total workforce (WHO, 2007). This is only strengthened by the fact that in 2003, for the very first time, a woman had been appointed as a minister - in this case, being the Ministry of Health (Ibid). Bahrain’s economic status can further be credited to oil and petrochemicals, as well as the manufacturing of aluminium, not to mention its banking, financial and commercial services. Unlike in other GCC states, Bahraini nationals are mostly enrolled in the private sector (66 percent of the employed Bahraini population as of mid-2018), whereas half (49 percent) of all foreign workers are confined to the lowest categories of occupation (Census, 2010).

Bahrain is a destination hub for migrant workers from India, Bangladesh, Philippines, Ethiopia, and Nepal seeking better opportunities in order to provide for their families back home - this often leaves them vulnerable to employer-led abuse, especially in regards to healthcare.

Health status indicators in Bahrain are comparable to those of developed countries. This is shown through the fact that life expectancy is 74.8, as well as reaching 100 percent coverage of basic vaccinations (WHO, 2007). However, Bahrain has witnessed an exponential rise in diseases such as cancer, cardiovascular and diabetes, with these currently representing the leading causes of death in the country (Ministry of Health, Health Information Directorate, 2006). In 2006, the figure was estimated at 742,562 as compared to 561,872 in 1994, with 38.2 percent of these figures consisting of non-Bahrainis (WHO, 2007).
Therefore, while comprehensive healthcare is provided to the whole population, as well as being subsidized to expats, private healthcare has seen growth in an unregulated fashion - posing a direct threat to migrants. Not to mention, the relationship and interaction of public and private is not well established. In addition, the system of mandatory insurance that will see the implementation of full government-subsidized insurance to nationals and partially subsidised insurance to expatriate residents is not to come into effect until after 2022. This poses a series of questions in terms of how effectively the system provides and meets the necessities of labourers and migrants versus its efficiency in serving the needs and requirements of citizens.

Over the past fifty years, the discovery of oil has catalysed considerable infrastructure developments in the GCC countries. This has contributed to the population of migrants of Bahrain making up 50 percent of the entire population (UN, 2017). With such a vast majority of the population comprising individuals serving on a short-term basis, it poses a pressing need to inquire about how efficiently the healthcare system has catered to their needs.

Unskilled low-income workers, predominantly male, usually hail from the nations of Bangladesh, Sri Lanka, etc. These migrants tend to be employed as construction workers, domestic helpers, cleaners, and drivers – jobs that are characterised by strenuous hours, low payment and a mentally and physically hazardous working environment. Of the migrant workers who make up 54.7 percent of the country's workforce, 99,500 of them are domestic workers - including 75,305 women (Migrant workers' rights, 2019). More than often, many of these migrants experience poor housing conditions and limited access to quality healthcare. With this in mind, these factors have inevitably contributed to a surge in work-related accidents and mental health problems. In 2013, 56 percent of all suicides committed in Kuwait were by domestic workers, with 81 percent of all suicide cases involving a South Asian migrant, and the other 19 percent comprising of African migrants (Migrants-Rights.org. 2013). Gross human right violations, including human trafficking, mental abuse, and sexual and other physical violence sometimes exacerbate these health risks.

In the context of the introduction of the new Bahraini Law No. 23 of 2018 ("The Health Insurance law"), this has been introduced by the government in order to provide compulsory healthcare coverage to all citizens, residents and visitors to the country from January 2019. The government will pay subscriptions for Bahraini citizens, whereas expatriate residents will need to be enrolled by foreign national employees. Therefore, with corporations bankrolling the payroll for bankers, lawyers, accountants and teachers, as well as Bahraini citizens being wholly subsidised by the government - where does this leave foreign labourers?

It is also expected that proof of insurance will be needed for expatriate employees for the renewal of employment and residence permits. With this in mind, if a migrant is unable to access medical insurance on his own terms, this will result in full and complete deportation without question. Not to mention, the Law has not specified what level of coverage should be provided. While expat employees of larger corporations receive top class insurance, labourers are left with poor quality insurance which ultimately renders them accountable to pay a certain amount of this coverage, disincentivizing them to consult a doctor in the first place. While this is undeniably a problem that must be addressed, changes are being put into action in order to address the immediate health risks of migrants. This includes:

Public health research and monitoring: population-based health profiles should include labourers and provide detailed information needed for adequate stratification of data on burden of disease, living circumstances, and access to health care services according to ethnicity, gender, and occupation.

Communication: culturally and linguistically appropriate health care services should be made available for low-income migrants.

Monitoring of progress: GCC countries should develop the means to assess and report progress in tackling health inequalities, thereby providing a means to monitor the impact of new policy initiatives.

Human rights initiatives: there should be a more government-focused approach to human rights initiatives, protecting migrants against discrimination as well as providing an outlet to overcome lack of citizenship for long-term migrants and/or their offspring to enable family reunification.

<u>Conclusions</u>

While the Gulf region can perhaps be deemed one of the world's most ethnically diverse regions, it is still considered one of the most unequal, especially in terms of access to adequate healthcare

resources. With economic progression only to improve, it is clear that the number of migrants coming into the country is only set to exponentially increase as well. Therefore, it is critical that changes and improvements in healthcare policy are able to fully represent the needs of the whole population, as opposed to targeting the elites of expatriates and nationals. While rapid progress has been made on engineering and technical fronts, there is an urgent demand for similar progress to be made in order to reduce healthcare inequalities and ultimately diminish the deficit in regards to healthcare access between nationals, expatriates and labourers.

Conclusion

As civilisations have flourished, healthcare provision has become more systematic. Public and individual health is the responsibility of the nation's healthcare system - whether it is controlled by the state, the free-market, or some combination of the two.

The sheer scale of the coronavirus outbreak has proven one thing beyond a doubt: everyone needs healthcare; if one doesn't have healthcare, then nobody does. At any moment, a single group's poor access to healthcare could endanger our species' existence.

That said, caring about someone's access to healthcare only because it might potentially affect you is selfish, and not a virtuous reason to support universal healthcare.

The Coronavirus pandemic has revealed that having a universal and well-funded healthcare system is crucial to the health of a nation's economy. It is only through upholding this ideal that, in turn, we will be able to design systems that will maintain public health most efficiently and effectively.

At the end of the day, if lives are not prioritised over the interests of a thriving economy, healthcare systems will not be able to ensure sufficient funding to overturn the same consequences we have faced in tackling our present pandemic.

With this in mind, we'd like to make some recommendations that will empower healthcare systems, when used effectively and ethically.

While blockchain technology has traditionally been associated with Fintech and cryptocurrencies, its ability to exchange information without an intermediary, as well as organising and structuring data to ensure it is not duplicated, but is instead up-to-date and immediately verified offers a gateway to explore ways of improving our existing healthcare system:

1. Blockchain technology would introduce a decentralised system that would ensure the free flow of information beyond the centre of a nation's activity, strengthening communication and reducing disparities between those accessing healthcare in cities versus individuals settled in less industrialised areas.
2. Blockchain technology would accelerate the findings in clinical and biomedical research, enabling us to control the activity of existing diseases while simultaneously tracking potential new ones. This could be defined as surveillance disease systems, which are: "systematic, ongoing collection, collation, and analysis of data and the timely dissemination of information to those who need to know so that the action can be taken." (John M. Last, 2001). This technology has the potential to identify health security

concerns, analyse preventative measures, and facilitate decision-making processes to act rapidly and effectively.

3. The switch to a decentralised system would address the economy's concerns in relation to the interruption in supply chains of traded goods. Blockchain will transform supply chain management through automated purchasing and better shipping data - companies like UPS, Maersk and DHL are already working on block-chain based solutions. In this way, through reducing costs and increasing efficiency, this will provide an opportunity to relocate funds to sectors that truly need it, such as healthcare.

While research in the area of 'blockchain technology in healthcare' is relatively new, and the ethics will have to be closely monitored. Through ensuring transparency, peer-to-peer transmission and continuity in supply chain management, this presents an opportunity to not only fortify our existing economy, but to ensure that healthcare is upheld as a fundamental right, reducing disparities to a point which could ultimately culminate in a universal healthcare system.

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