**UNIT 2: Reasoning about Health**

Overview: This background unit introduces the notion of protected values and how they can complicate discourse regarding healthcare. The presence of protected values creates resistance to explicit tradeoffs, creates effects from problem frames (or descriptions), and encourages biases towards omission and status-quo maintenance.

Learning Objectives:

1. Understand protected values
2. Recognize protected values lead to omission and status-quo biases

Role in Course: Unit 2 provides general background. You won’t have direct deliverables related to this content. You should find it useful to be cognizant of the role of protected values and related biases when you assess or engage in policy discussions, debate, and / or decisions around value-based care. This is true for team project and case discussions as well as for your own professional roles. For instance, when making team project recommendations, you should be aware of the potential for serious resistance to any policy suggestion requiring tradeoffs that impose new health risks on a specific population.

**Protected Values: Definition**

Decisions are defined by tradeoffs. Tradeoffs exist when to get more of one thing we have to give up something else. We’re constantly making tradeoffs, although sometimes we make them implicitly, that is, we don’t consciously acknowledge or admit a tradeoff is being made.

Healthcare-relevant tradeoffs range from simple (e.g., giving up a small monetary fee to get very beneficial care) to truly difficult (e.g., risking a fatal side effect to mitigate significant disability). They also occur at both the individual level (e.g., side effects versus health for a patient) and the societal level (e.g., public funding spent on one individual is not available for another).

Some healthcare tradeoffs involve **protected values** where explicit tradeoffs are taboo (or considered morally or socially unacceptable). Protected values might include human life, environmental protection or religious or cultural values. These values resist trade-offs, particularly economic tradeoffs. For instance, individuals generally believe it is immoral to sacrifice a life for monetary gain.

The resistance to trading off protected values is generated from basic moral rules. For instance, many of us see protecting living people as a general, universal moral obligation, independent of individual preferences. For instance, I shouldn’t directly interfere with another person’s health or safety, no matter how much I might prefer to do so for my own gain.

We often seem to generalize these very reasonable rules such that we resist making any tradeoffs about protected values such as life, safety, or health. Decision makers tend to express anger at the thought of making trade-offs regarding protected values and / or to deny the need for such tradeoffs.

Protected values can complicate our discussion of healthcare and health policy. They can make us sensitive to not just what we’re deciding, but how we’re deciding. They also create or exacerbate some decision biases.

**Protected Values: Implications for Decision Making and Policy Debate**

We can understand the impact of protected values with several common experimental findings, as summarized below.

*Direct Tradeoffs*

Decision makers resist explicit health-money tradeoffs, even as compared to identical decisions where tradeoffs are made implicitly. For instance, a firm described as estimating its device will cause 10 deaths will tend to be judged more harshly than a firm described as estimating its device causes a 1 in 1 million risk of death in a 10-million patient market. This occurs even when both situations are normatively equivalent in terms of the actions and information described. More generally, one of the ways decision makers tend to deal with protected values is by making the relevant tradeoffs implicit rather than explicit. We accept that a 1 in a million risk of death sounds pretty small and we might be happy to accept that risk, but once I make explicit the cost or harm to the 10 patients, the risk seems more difficult to accept.

Resistance to tradeoffs complicates values-based care initiatives because explicit tradeoffs made as part of cost effectiveness analysis are often necessary for value-based decisions about individual and population health.

One way to get past this bottleneck is to acknowledge that tradeoffs exist whether they are explicit or implicit. If we don’t have unlimited public funding, then tradeoffs will happen, the question is simply whether they are explicit. It may seem silly to have to continually back up and make this point, but it’s often very necessary to do so. For instance, a review of the outcome of past policy decisions can be used to help stakeholders realize the actual implications of past actions. For instance, many policy decisions either implicitly if not explicitly ascribe monetary values to human lives. Pointing to the implications of prior policies can help make clear that we have to value life whether we want to or not (and also that values can vary widely). This might help people see that it is worthwhile to have consistency in such an important estimate. Note, also, that cultural and historical factors are important. For instance, cost-effectiveness analysis is more accepted on average in the UK than in the US simply because the UK’s National Health System has been making the relevant tradeoffs explicit and transparent for many years.

*Omission Bias*

When protected values are relevant, we tend to focus on, and judge, the person or entity that is perceived to be acting. Generally, action signals intent and hence moral relevance. We might overgeneralize this prohibition on action and judge the decision maker when it’s really the situation that is a problem.

For instance, this judgment of actions can complicate how we evaluate treatment because the same clinical action may be described, or framed, in different ways. So, a physician described as” intervening to treat the patient” might be held more responsible than a physician described as “providing the standard of care.” The first description highlights the physician’s own agency, or action. In this situation, the physician will likely be perceived by others as more responsible for the relevant outcomes and will likely be judged more harshly by others for any negative outcomes.

It is possible to leverage the omission bias in policy discussions. If you have an objective in mind, you want to frame discussion such that benefits are described as resulting from action and harms are described as resulting from inaction.

*Status Quo Bias*

The status quo bias reflects that all else equal, we tend to prefer to maintain the status quo situation over change from the status quo (usually seen as requiring action). This effect tends to be stronger when protected values are involved.

Sometimes, the same action can be framed as either consistent or inconsistent with the status quo. For instance, a firm responding to data about a side effect can be described as either “making a decision to launch” or as “doing nothing and proceeding with existing launch plans.” Even where the descriptions are logically equivalent, people tend to judge the firm more harshly given the first description. Because the exact nature of the status quo often shifts with perspective, or description, we can make the same outcome seem more or less acceptable. As with the omission bias, one might be able to leverage this effect by describing desired outcomes as consistent with prior policy, general guidelines, or other factors creating a perception that they are consistent with the status quo.

**Unit 2 Summary**

Unit 2 reviews important sources of difficulty in talking about healthcare. These are:

* Values involving health and life tend to be protected against tradeoffs, and that this protection creates predictable effects that complicate discourse.
* These complications include: Aversion to explicit cost-benefit tradeoffs, Aversion to actions over equivalent omissions, and Preference for the status quo.

These effects are quite deeply engrained, so we don’t really know how to fully eradicate them. However, we do know a bit about how to frame or describe decisions to minimize the difficulty these biases present. For instance:

* It’s often useful to acknowledge that protected values exist, and to remind stakeholders that if the relevant tradeoffs aren’t explicit, they will be implicit.
* It is also useful to use descriptions or frames that de-emphasize action and change when dealing with protected values. For instance, a particular intervention will be more readily accepted if it is described as the result of a longstanding, consistent policy to use evidence-based care (e.g., as following from status-quo policy) than if it is described as the result of an active decision to implement an intervention (e.g., as following from an active decision to act).

More generally, Individuals and organizations anticipating these difficulties are better positioned to manage the often-extensive discussions generated by aversion to tradeoffs, actions, and moving off of the status quo.