

## Diabetes and Welfare

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There is growing empirical evidence that confirms what most of us know intuitively – that the poor have a harder time controlling their diabetes than those of greater means. A couple of recent papers by Dr. Seth A. Berkowitz will serve to illustrate. In [one](#), Berkowitz and his coauthors found that a number of indices of “material insecurity” were associated with poor diabetes control; of the various factors they studied, food insecurity was most closely linked. In [the other](#), Berkowitz and colleagues found that unstable housing was associated with a staggering increase in visits to the emergency room or hospitalization for diabetics (adjusted odds ratio 5.17; 95% CI 2.08–12.87). These individuals are not homeless: “housing unstable” means that they can’t pay rent/mortgage, that they moved two or more times in the last twelve months, or that they live in a place they do not own/rent. Less than 1% of these patients received help with their housing. In the meantime, many more people are what one might call “housing precarious.” A [Harvard report](#) noted that a quarter of all renters paid half or more of their income for housing, and underscored that “much to their detriment, cost-burdened households are forced to cut back on food, healthcare, and other critical expenses.” Here in Charlotte, a [2017 report estimated](#) that the city had a deficit of 21,000 units of housing that would be affordable to someone making less than 50% of the city’s median income.

This presents both a moral and an economic problem. The economic problem should be clear enough, and can be put this way: it is almost certainly cheaper to assist with housing than it is to pay for ER visits. As Berkowitz notes, diabetes cost the U.S. \$217 billion last year, including more than 21 million ER visits and hospitalizations. A [Kaiser Health News report](#) from 2010 found that diabetes then cost \$83 billion a year in hospital spending, or 20% of total hospital spending in the U.S. [Research in Diabetes Care](#) estimated that, in 2012, “40% of all health care expenditures attributed to diabetes came from higher rates of hospital admission and longer average lengths of stay per admission, constituting the single largest contributor to the attributed medical cost of diabetes.”

Behind the obvious fiscal reasons to trim diabetes-related hospitalizations, however, lurk some difficult moral issues. It seems to me that findings like these suggest that we need to expand the social safety net – welfare, if you prefer – dramatically, if we as a society want to say that we care for low-income people with diabetes. On welfare, we have been doing the opposite at least since the 1996, Clinton-era welfare reform legislation. There are lifetime maximums on TANF, and [three-year limits](#) to SNAP for many people. These recent studies remind us that social determinants of health matter, and that one way of addressing those is with traditional welfare programs that are in a twenty-year decline. Of course, even here there are questions: the logical extension of providing housing assistance to

those with diabetes is further expansion of the safety net, perhaps by ramping up food assistance.

That said, the difficult problem is not, I think, of deciding how far to extend assistive welfare programs. If one frames the problem as reducing noncompliance with treatment regimes, it becomes apparent that there is another continuum, this one based on how coercive the help with care management is. Strictly assistive programs such as housing or food subsidies pose no special problems here. Somewhat more contentious would be efforts to make non-compliance more difficult, such as a steep tax on sugary drinks. Our experience with cigarettes shows that this sort of thing can make a difference. Much more contentious would be efforts to directly induce compliance; new technologies are rapidly making these more economically viable. For example, there are now pills that [know they have been ingested](#) and can report this information. Simpler devices like fitness trackers could also provide useful information.

In my view, programs in this last category are morally questionable. First, they don't address a fundamental problem, which is that being in unstable housing makes it more difficult to comply with a medical routine. Second, they pose serious questions about patient privacy and autonomy. Finally, they leave unanswered the question of what to do if patients don't follow their care regimen: would you deny them treatment? Hertfordshire in England has started down this path, [banning elective surgery](#) for those who smoke or fail to lose weight if they need to. This last point about privacy and autonomy suggests an unusual wrinkle to old debates about welfare: here, it looks like housing assistance from the state is better for individuals' autonomy than other efforts to get them to maintain treatment regimens.

However you resolve the moral issues, it seems to me that as long as we accept a moral and legal obligation to treat those who arrive at the emergency room with poorly-managed diabetes, the question is really about what kind of dependence on the state is preferable, and the way that we want to pay for that dependence. At the end of the day, we tend, as a society, to look at healthcare and healthcare expenses in a vacuum. Dr. Berkowitz's work provides an evidence-based reminder that this is myopic.