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Editorial

When Ideology Trumps: A Case for Evidence-Based Health Policies

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In this issue of *The American Journal of Bioethics (AJOB)*, Adina Preda and Kristin Voigt (2015) investigate the relationship between health policies, social determinants of health, and health inequalities. There is much empirical work demonstrating the correlation between social determinants of health and health outcomes, which establishes a clear relationship between a person's social and economic status and her health outcomes. What are defined as social determinants of health varies depending on institution or organization, but the World Health Organization (WHO) broadly explains social determinants of health as "the conditions in which people are born, grow, live, work and age" and further, that "these circumstances are shaped by the distribution of money, power and resources at global, national and local levels" (World Health Organization, Social Determinants of Health. n.d.). Preda and Voigt agree that social determinants of health are unavoidably tied to health outcomes but, importantly, they question the resulting normative claims used to inform policy recommendations. Their target article investigates some possible consequences of using a social determinants of health approach as our normative backbone to policy recommendations.

One challenge in dealing with negative health outcomes emerging from social and economic factors is that policies are often driven by ideology and biases rather than evidence. For example, most countries struggle to manage drug addiction though health policies, though drug use rates and treatment options vary from country to country. Many countries have, at one point or another, enacted drug policies that are influenced by ideology instead of evidence, including the depiction of drug use as a character flaw or moral weakness (including our own "Just Say No" campaign circa Nancy Ragan in the early 1980s). Policies grounded in ideology that focus on eradication as the goal often lead to the misapplication of criminal law, arbitrary health policies, and, as a result, can negatively impact the health of not only that specific population but that of society as well.

People who inject drugs (PWID) present a unique and noteworthy example in demonstrating how unsound health policy can lead to negative health outcomes. Injecting drug use poses a set of specific health risks and most countries encourage safety precautions and rehabilitation treatments for PWID to minimize their risk of exposure to HIV and other infectious diseases like tuberculosis and Hepatitis C. These precautions include the implementation of harm reduction measures and typically take the form of needle-exchange programs with opioid substitution therapy, such as methadone or buprenorphine. Both of these approaches are on the WHO model list of essential medications and have been used as rehabilitation treatment for injecting opiate users for over forty years. Simply put, they are "still regarded as the most effective" rehabilitation treatment (WHO 2013). The interesting feature of harm reduction policies is that they are primarily meant to reduce the harm of an existing practice (such as drug use) without requiring that the practice be abolished.

The success of substitution therapy, primarily in the form of methadone, has been widely studied in a variety of countries and exhaustive empirical data supports its multi-faceted success. Methadone proves to be not only a safe substitution to heroin, but one that reduces the risk of HIV amongst PWID. Moreover, it is effective at retaining PWID in treatment, reduces criminal activity, is cost effective, and improves both physical and mental health and quality of life for both rehabilitation patients and their families (Rufener et al. 1977; Ward and Sutton 1998). Despite these positive results, methadone—and indeed every other form of substitution therapy—is illegal or unavailable in some countries, including Russia.

This resistance to a proven successful and inexpensive health policy has left Russia with one of the fastest growing epidemics in the world, with injecting drug use accounting for close to 70% of new HIV infections. Russia also happens to be one of the world's top consumers of heroin, with United Nations Office on Drugs and Crime estimates of over 2.5 million injecting opiate users, totaling

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about 2.29 percent of the county's population–more than any other country in the world (United Nations Office on Drugs and Crime 2014). Yet the implementation of harm reduction measures continues to be controversial in Russia and almost all treatment options for Russia's injecting drug users are abstinence-oriented. Russian physicians themselves were amongst the strongest agents behind the resistance to substitution therapy, arguing that offering methadone is merely "substituting one drug for another" (Krasnov et al. 2005, 2).

The consequences of Russia's drug policy are alarming and unambiguous — no matter where you stand, it's easy to recognize that their current system doesn't work and only exacerbates their HIV problem. Health outcomes are worse when biases direct health policies instead of evidence. Preda and Voigt ask, "Why [in matters of social and economic inequalities] we would focus on *health* inequality rather than social inequality?" (Preda and Voigt 2015, 30). While possible to focus on social justice as an approach, the application runs the risk of being used as a thinly veiled disguise for using prejudice and biases while avoiding good evidence-based approaches. If social justice alone legitimizes our health policies, then policy-makers can throw any evidence out the window. This point rings especially true for already disadvantaged populations like drug users or those of low socio-economic status. ■

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