Justice and the Allocation of Healthcare Resources

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All over the world healthcare systems are said to be in "crisis." Underneath the rhetoric of such claims there are some serious issues which challenge Christians and all people of good will. On the one hand, some countries are unable to provide even the most basic standards of healthcare for their populations. Others can provide very basic healthcare for all, but little more, except for those with money. Others again could provide very good healthcare for all, but do not: even in a country as affluent as the United States, where $US1.5 billion is spent daily on healthcare, over a quarter of the population is unserved or underserved due to lack of any or adequate insurance and there are currently proposals to ut the care to the elderly and poor. And other countries manage to provide more of less universal coverage of a fairly good standard, but even in these there are usually complaints of long queues and various problems with access and comprehensiveness. In no country is there a medical money tree from which healthcare services can be picked *ad infinitum* and governments, insurers and patients throughout the world are resisting further cost increases.

Healthcare resources include budgets, hospitals, beds, equipment, the time and energies of health professionals, drugs, procedures, organs-for-transplant and the like. Allocation, distribution, rationing, or prioritization of these resources always occurs, whether implicitly through the free market and supplementary welfare programmes, or more explicitly through some grand government or insurance plan. Rationing is unavoidable because of the finitude of human fife and health, technology, institutions, and natural resources. Even were we substantially to increase healthcare spending the simple fact is: not

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everyone can have every possible healthcare service. Nor would this necessarily be desirable even were it practicable. Furthermore there are *opportunity costs* with every choice: for everything we choose to do in medicine we forego doing certain other things.

The basic ethical question in healthcare allocation is therefore NOT whether we should ration or prioritize but how we should do so, given that this is inevitable. On what basis should we ration our healthcare resources? A variety of standards are proposed and are already in various ways and places: equal opportunity, need, ability to pay, physician preference, social contribution, consciousness, quality of life, age, personal responsibility for illness, other responsibilities.

In the past few years there has been a proliferation of professional literature and political statements about healthcare allocation questions. There are four recurrent themes in much of that writing. First, it is widely asserted (by the Catholic Church, among others) that healthcare is a right — though the basis, scope and limits of this right are rarely explained. Secondly, the costs of providing adequate healthcare for all are said to be beyond the capacity of individuals and communities to bear. Thirdly, it is proposed that the careful application of utilitarian and economic techniques could establish a more rational system of healthcare allocation. And finally, health systems are charged with being riddled with inequities, such as:

• underspending on healthcare (compared with demand as demonstrated in mortality, morbidity and queuing figures or compared with percentage of GNP spent by comparable countries or compared with spending on other goals — as where a government spends several times as much on defence as on healthcare); or

• overspending on healthcare relative to other social goods (so that even were health regarded as the prime objective it would be more efficiently served by improved housing for the poor, environmental protection, etc. and less spending on healthcare); and

• a disproportionate focus on disease rather than illness, and on ill-health rather than health.

• a crisis orientation which leads to overspending on acute care and underspending on preventive measures;

• a fascination with technology which leads to overspending on 'hi-tech' gadgetry and drugs and underspending on other kinds of

healthcare (such as simpler remedies, immunisations, palliative care, alternative medicine);

• over-institutionalisation, which leads to overspending on hospitals and underspending on home- and community-based programmes, survelliance, midwifery etc.;

• overspending on particular regions, cities, institutions or wards and underspending on others, especially islands and rural areas distant from the capital;

• overspending on patients and particular therapies or disciplines or medical workers with particular political, ideological or emotional clout, and underspending on others with less influence; and

• unjust discrimination, above all on the basis of ability to pay, but also at times on the basis of factors such as who you know, gender, age or handicap.

The problem with charges like these is that they are commonly made without offering any reasoned account of how we should judge a distribution unjust. Without coherent moral principles such claims may well be mere question-begging, prejudice and interest-peddling. That said, there *is* reason to believe that, by almost any standard of justice, there are widespread, systemic and radical misallocations of resources in most societies and health systems and that there is a real risk that these will worsen in the future. Unless some attempt is made to apply canons of criticism offered by philosophical and theological reflection on justice, these misallocations are likely to continue unexamined.

The Questions

Unless there is systematic ethical examination and criticism of healthcare distribution, there are likely to be inconsistencies and abuses in the way this good is allocated. And unless we as Christian health professionals a Church do such thinking we will fail to be prophetic regarding a major social good and could be omplicit with, even identified with, the Rich Man in Jesus' parable who left Lazarus unattended while he gloried in his luxuries. Such an examination must begin with a clear sense of the complex of issues involved in any apparently simple question like: *is our current pattern of allocating*

healthcare just? We must be clear that we are actually asking or begging a whole range of questions when we address the distribution issue. Healthcare allocation questions might for convenience be put into three groups: macro questions, meso questions, and micro questions.

The first (macro) issue is, roughly speaking: *how much should be spent on healthcare?* To answer this requires inquiring into issues such as: what kind of good is healthcare or what kind of ends does it serve? Should healthcare be regarded just like any other commodity or service, or does it have special features? Is there a fight to some level of healthcare and a social obligation to provide it? If so, what is the minimum entitlement and obligation? Why and to what extent should healthcare be given priority over other social goods? What proportion of a community's resources (time, money, energy ...) should properly be devoted to this good, and what to competing social goods such as education, eliminating poverty, improving the environment, defence and so on? Or should this simply be left to the operation of the free market and political jockeying? Can there even be a rational basis for determining the total healtlhcare spending? Or local budgets? Or is this best left to politics and tradition? What principles of morality prescribe and proscribe what we can do in the pursuit of more efficient allocation of healthcare?

The second, *meso-allocation* question is: *how many of the healthcare resources should go to what kinds of services?* This can be unpacked by asking: what kinds of goals should the health system be addressing, and in what order? Are health promotion measures, for instance, to be included? Is the present distribution of resources between broad categories such as health-promotion and crisis-care fair and efficient? Should optometry, chiropracty, dentistry, psychoanalysis or aromatherapy be included? What specialties should a particular hospital develop? On what basis are choices between possible types of healthcare to be made when not all call be afforded? What limits does the proper freedom of physicians, healthcare institutions, insurers and patients place on any scheme of just allocation of healthcare? Is the provision of healthcare without regard to efficiency morally acceptable or even required?

The third, *micro-allocation* question is: *who should get what share of the healthcare resources?* Is the present distribution of healthcare resources between persons 'equitable' and 'efficient'? What

inequalities in healthcare distribution are morally acceptable? Who is to receive a particular treatment when it has to be rationed? Should factors such as religion, race, gender, age, ability to pay, regional and social location, be important? Should we, for instance, prefer the young to the elderly? Should physicians try to do 'everything possible' for their patients, irrespective of the needs of others? What principles of morality prescribe and proscribe what we can do in the pursuit of more efficient micro-allocation of healthcare? In its starkest terms: who is to be saved when not all can be?

The problem of healthcare distribution does not only arise when being addressed directly. Time and again it rears its head when treating other bioethical questions such as the appropriate treatment of newborns, the infertilie, tlie chronically sick and the terminally ill, the permanently unconscious.

Justice in healthcare allocation is already the single most important bioethical question. With the explosion of supply of healthcare technologies and of demand for them (each fueling the other), and the parallel increase in costs and need for rationing, many of healthcare decisions are already being made and will increasingly in the future be made on the basis of dollars and cents-but not without opening a whole new ethical 'can of worms': justice in healthcare rationing.

Stewardship For Our Own Health

How is one to begin to answer these questions? Most writers go straight to the kinds of intuitions and grand theories and econometric techniques I have already mentioned or will treat in the last section. That, I think, is wrong-headed. We have to begin with examining what we are about when we do medicine, what it is for, what our basic responsibilities are.

A first principle might be called "stewardship for our own health." The prime responsibility for healthcare belongs to the individual: the duty to care for our own health (and that of the other family members) and to use reasonable means to meet healthcare needs. The theological source of this responsibility is our stewardship over and reverence for our own bodies and lives, our 'talents', as part of our stewardship of creation. A range of duties follow. We should, for instance, seek and act upon reliable information about hygiene, diet, rest, exercise,

substance use and abuse, safe practices, moderation, and, when we are sick, the healthcare options. We have a duty (and should be given the room) to challenge contemporary practices which threaten our health, and to develop virtues and an overall style of life suited to our true flourishing as human beings and believers. We have a duty to seek help from others in our healthcare when we cannot provide for our own needs, and a corresponding duty to help others in their healthcare.

The notion of 'need' —that without which a person cannot flourish— requires a lot of unpacking. It must be distinguished from other preferences, false needs, lacks, drives, dependencies and addictions. There are good reasons for individuals to seek to satisfy their needs; indeed, health needs have a certain natural priority over many other needs and preferences, and there is a *prima facie duty* to address them. Such needs, where they can be logically ordered or sorted (e.g. life-saving before cosmetic surgery, primary care first), they should be addressed in order of importance.

None the less these duties must be situated within the broader context of people's real possibilities given their resources and insight, and their own vocations, and harmonized with the pursuit of other goods and other responsibilities. Thus while never neglecting life and health entirely, the means one uses to protect and promote them will have proper limits.

I *AM* my Brothers' Keeper: Justice and The Golden Rule

The second principle which I would like to propose is the principle that, in a sense, I *am* my brother's (and sister's) keeper. Communities exist to serve persons. Among other things, communities often provide those prerequisites of human flourishing we call 'needs' and this can be elevated to the normative status of a 'right'. If we are to have hospital care, or modem therapies such as drugs, or public health measures such as sanitation, or preventive programmes such as vaccinations, we need to cooperate in their provision. Clinics, hospitals and health systems are partly vehicles for self-preservation and improvement. But they are more than this: they are a parable which expresses justice, fellow-feeling, compassion, social conscience, solidarity, reverence for human life, service of the common good.

There is much in the Christian social tradition to support the notion of a right to some basic level of healthcare and that any rationing must be (a) respectful of individual human dignity; (b) oriented to the common good and (c) free from wrongful discrimination.

People have an ethical claim on the community in general, and the healthcare community in particular, for help in the maintenance of their health. So the Church and the United Nations say we have a right to healthcare which governments and communities must seek to satisfy. When in poorer countries a community cannot reasonably provide a decent minimum standard of healthcare, this ethical claim or 'right' is only a weak one: a description of a human need and an assertion of the moral duty, as far as is possible and reasonable, to restructure or develop that community so that it can be satisfied. In this situation health professionals, specially physicians, have three special responsibilities: first, to distribute some of their time and energy to the poor, and not to give their attention exclusively to patients who can pay; secondly, to redistribute some of their well-above average incomes to those who have much less than they need; and thirdly, to use some if their considerable power and influence with a view to social reform a direction which will allow the satisfaction of the fight to healthcare. The desire to protect one's own interests and autonomy does not excuse failure in these three respects. "From the one to whom much is given, much will be expected."

This view challenges the liberal individualist ideology which absolutizes individual efforts and private property and maximizes the right to dispose of such property (and other talents, powers and opportunities) as one wishes. Christians believe that God gave the earth to the whole human race to provide for the needs of all, and thus while private property is often a requirement of justice, the needs of others establish duties on the part of those who have more than they need towards those who have less than they need — in healthcare as in other basic human needs. Redistributive justice is served by service to others, giving appropriately to charities, paying just taxes, and by the provision of charitable organizations and government social welfare programmes. While Christian views of justice do not prescribe any particular solution to the public policy question of the appropriate mix of public and private provision of medicine, distributive justice would seem to exclude 'ability to pay' in a free market as the sole or ruling principle of healthcare rationing.

To distributive justice Christian faith adds another concern: to give special care to the underprivileged, powerless and desperate ('the preferential option for the poor'). Thus among the various just regimes of healthcare distribution which are possible in any community, the Christian will prefer the one which gives special care to the most needy and most defenseless, which gives priority to the disadvantaged. The call to mercy invites persons to go beyond the principles of justice in promoting the welfare of others, without of course violating the requirements of justice (such as subsidiarity). Unique among social institutions and practices, healthcare has as its mission the saving of lives, the improvement of health, the care of frail, sick and injured persons; persons join this profession with a commitment to serving others in this way. Healthcare would suffer a major distortion if the rationing principles of health economics or the free market or bureaucratic efficiency became its principal motor.

Having argued that in healthcare as elsewhere, I am (without being paternalistic) in some sense my brother and sister's keeper, the question arises as to what style I am expected to keep my brother in and what I am to do when two brothers have rival claims upon me. Dispositions of justice and mercy take us a long way in answering questions like whether there is a right to healthcare, but they do not unpack for us what that right will amount to in the concrete. One useful test of the justice of healthcare allocations is an adaptation of the Golden Rule: *would I think the system was fair if I (or someone I loved) was in the weakest position in the community (i.e. sick with a chronic, disabling and expensive ailment, poor, illiterate etc.)?*

Compassionate Solidarity and Healthcare Good Samaritans

Much of what healthcare workers, and the complex institutions of which they form part, do they do as agents or delegates of the individual patient and the community. This delegation is, for instance, the source of the principle of informed consent; it is also the primary premise for any resource allocation by them. Thus any institutional attempt to deal with healthcare allocation must accommodate the duty of the individual to take care of his/her own life and health; the duty to always reverence and nurture human life; the need to give people opportunities and encouragement to live responsible and healthy lives; the duty of communities to serve persons; the reasonable

expectation ('right') of people to assistance from the community for their healthcare needs, and the corresponding duties to contribute to the needs of others and exercise restraint in the demands they make; the limits to private property and provider autonomy; the duty to provide special assistance to the needy and defenseless; and the duty to redress the series of maldistributions which the application of tests of justice and efficiency to present healthcare allocations suggest.

In addition to the constraints on allocations which follow from the roles of healthcare providers as (a) delegates of the individual patient and (b) delegates of the community, there are certain responsibilities which flow from their roles as (c) professionals, (d) practitioners, and (e) people with a religious vocation. For the Christian healthworker the model is surely that of the Good Samaritan; and much secular medicine has adopted this language of *service* to individuals and the community. Sometimes these quasi-religious duties will seem to conflict with the goal of just or efficient allocation of healthcare resources, to interfere with doctor-patient relationships, with the special medical drive and virtue to save-cure-care, to 'put patients first'.

Primum Non Nocere

Healthcare workers have positive and negative duties: the responsibility to do and restrain from doing certain things. So far I have mainly treated the positive duties of healthcare workers: duties of respect and care. Yet the classic starting point of medical ethics was the dictum *primum non nocere.* As the Hippocratic Oath puts it: 'I will use treatment to help the sick to the best of my ability and judgment, but I will never use it to injure or wrong them'. Or as the broader ethical tradition has taught: 'The end does not justify the means', 'Never treat anyone as a mere means', 'Do not do evil that good may come'.

Among the kinds of medical maleficence which are sadly not uncommon are 'white lies' told to patients (e.g. telling elderly patients they would not benefit from a therapy when our real reason is we want to distribute it elsewhere), mutilation, unjust discrimination, and medical homicide. Medical homicide has recently been proposed as not only the 'merciful' way to treat the handicapped and those in severe pain or incurable illness or coma, but also the most 'efficient'

way of distributing finite health resources. But it seems to me that to try to solve resource shortages by killing or abandoning the expensive is a counsel of despair, and no more justifiable than 'solving' the problem of the starving millions by 'dropping nuclear warheads on them. Respect for human life should not be compromised for the sake of more efficient healthcare allocation.

Behaviour, Age, Social Value, Special Responsibilites

Should factors such as the patient's own responsibility for the illness (e.g. where he smokes), their age, social contribution or special responsibilities be taken into account when distributing healthcare resources? In principle where injuries/illness are partly or wholly self-inflicted some greater financial burden might reasonably be borne by some patients. But even if a patient did not or could not make some extra contribution, we do not normally 'abandon' people just because they 'brought it on themselves'; rather we instinctively rescue, for very good reasons which I will discuss at the end of my paper. Attempted suicides are the clearest example: but there are those with sporting accidents, drug problems, sexually transmitted diseases, pregnancy... Causation and responsibility in sickness are very complex: rarely is *there a single, specific cause; rarely can we say of a patient "Mr. Bloggs deliberately chose to bring this illness on himself knowing the risks and without anyone else being responsible."* People's behaviour is determined by a complicated mixture of upbringing, social group, physical and psychological addictions, and personal choice. And if people are to be penalized for taking unreasonable risks with their health, what kind of risk is a reasonable one? Is driving a car?

Another standard proposed for excluding patients from treatment is that they are over a certain age. This is already informally the case with certain treatments in certain countries. If the basis of this exclusion is that because of her advanced age the patient is unlikely to benefit, or is significantly less likely to benefit than others competing for the therapy, this is no more problematical than other distributions on the basis of need and capacity to benefit; but age is a very rough guide to prognosis and it would surely be better to look at this matter directly. If the basis of the choice of age criterion is in fact lower expected quality of life, or lower expected future social contribution, these again should be argued for and applied openly. But the age criterion might be based (explicitly or not) on some kind of 'fair

innings' assumption: that over a certain age people have less moral claim upon the resources of the community for the maintenance of their health and the extension of their life. Where two patients aged 20 and 80 are rivals for the same kidney transplant, most would prefer the younger patient even if all other things (prognosis) are equal.

A good case can be made for some such ageist discrimination. If the purpose of social provision of healthcare is at least partly to give everyone a fairly good chance of a reasonable length of life in reasonable health, that system heavy pressed with various competing demands might reasonably taper off its care once that 'reasonable' level of health and length of life are ensured. This would not have to amount to complete abandonment. But it might mean that higher technology or higher cost therapies were not available to the very elderly, or at least not at the state's expense.

On the other hand, this goes against the egalitarian ideal which informs much of social welfare policy and which has support in threads of the Christian tradition. Many societies undervalue their elderly members and increasingly shows signs of a real ageist prejudice. In such an environment an age criterion in health distribution might reflect and itself generate further prejudice against an already vulnerable and relatively powerless group. Christianity has inherited from Judaism and has in common with the great Asian religions a special concern for the widowed, the elderly and the powerless, groups very much at ask in present efforts to economize and rationalize. Piety, respect for elders, filial affection and duty are Christian virtues which seem to receive rather short-shift in ageist healthcare allocations.

One standard of healthcare allocation which I will merely flag here is past or expected future social contribution. On this view those who put the most into society should get the most out of it. They are objectively, or at least relatively, more valuable than others who contribute little. Leaving aside the obvious practical difficulties of who and how one would calculate and compare a person's social contribution (should politicians, for instance, be regarded as contributors at all? should priests?) and the problems of feasibility in the medical context (can we imagine emergency care staff doing quick personal history and social value profile before deciding who to treat and who not?), there are some fundamental objections to this in principle. The making of social value judgments is invidious and runs contrary to such fundamental principles as the equal dignity and

unconditional worth of all persons (as images of God), equal concern, respect and fights of those with such dignity, justice as giving to each her due. It values people instead as mere means to the ends of some shadowy and potentially totalitarian entity such as 'society' or 'the state'. To deny healthcare to those who make insufficient social contribution is likely to compound the disadvantage and discrimination already suffered by the handicapped and those belonging to various disadvantaged groups in our community. Such an approach to healthcare distribution runs clear contrary to the Christian tradition of preference for the socially unproductive (the widows, orphans, lepers, adulteresses, the hungry, thirsty, sick, imprisoned, foreigners etc.), to other egalitarian views of justice, and to the traditions of medicine as a profession and social practice.

There is, however, a much stronger argument for discriminating in favour of those with special responsibilities: patients with dependents and people who are especially necessary for the common good (e.g. doctors in wartime). Part of the purpose of healthcare institutions is, as I have suggested, to support such groups and values. By helping such persons we help others as well: the children, for instance, of a sick young mother. There are, however, dangers that this criterion can shade into the social value criterion just examined. Are we to prefer the President over a supposed nobody on the basis that the President's death would cause social and economic chaos in our community?

The Good Accountant -v- The Good Samaritan

In the last part of this essay I will compare two models of the ideal health professional. The first, and more recent one, is that of the good accountant. The good accountant seeks to get the most value out of each healthcare dollar. 'QALYs' (quality adjusted life years) are one currently fashionable attempt to allocate resources according to cost-benefit. They attempt to prioritize which services will be made available given the limitations of resources according to those which give the maximum benefit per dollar spent. Benefit is measured in terms of life-years (or their equivalent) gained as a result of the therapy in question, modified by the 'quality of life' of those years added, the side-effects, and the probabilities involved. This is only one example of an economic and utilitarian approach to healthcare allocation which is being widely proposed. The famous Oregon experiment in prioritizing health services is another example.

The temptation for the good accountant is always to seek the most efficient way to use resources, a good object if not the only worthy one. But it is naive at best to imagine that there can be some *value-free* method of allocating resources wisely, somehow made objective by the introduction of measures and formulas, social surveys and opinion polls. In the first place, this is because *efficiency* is always to be judged according to its end: it is logically impossible to judge if our allocation process is efficient without first establishing a vision of integral human good, moral reason, and the purpose of healthcare in which to contextualize the allocation and make an assessment of how well it serves. Assessing healthcare distribution is unavoidably a *normative* task: we must ask the hard questions about what medicine and justice are about which I have mentioned already. Efficiency ratings may well be useful in assessing alternative strategies once we have worked out — on other grounds — what our objects should be.

Secondly, quality-of-life and other utilitarian ethics raise more questions than they answer. It is never really possible to predict, measure in advance, aggregate or compare all the good and bad results of our choices, and this is all the more obvious in healthcare. What is quality of life or utility? How is a QALY calculus to account for the occurrence, timing, gravity, persistence and probabilities of the costs and benefits of particular allocation systems and decisions? Even were they calculable, how could they be reduced to a single measure? Even if one individual could make such a comparison in his/her own case, how are interpersonal comparisons to be made? How are the consequences to be assessed where they stretch into infinity? Are patients properly reduced to loci of QALYs? Are health workers properly reduced to QALY maximizers? And so on.

Thirdly, an ethic determined by *aggregated preferences* will fail to respect important values such as justice, liberty, human rights, and virtues. However good an overall result may seem in terms of resource distribution and heathcare efficiency, some options will be excluded because all human beings are entitled to respect as such and are never to be reduced merely to means to ends, even worthy ends such as healthcare efficiency. Thus any genuinely just distribution must take proper cognizance of the range of moral matters which come into play in any treatment decision, such as the duties of equal care and respect for the sick, and duties not to kill or harm them.

Contrary to the model of the good accountant, then, there *can be* values in doing the apparently inefficient. We may, for instance, feel

we simply have to respond to a crisis, like the Good Samaritan. The rescue imperative is instinctive but can also be the appropriate reaction of a virtuous and reasonable person. There can be good practical reasons for encouraging this instinct and habit, both for the individual health professional (who wants to be able to make quick and good decisions in a time of emergency) and for the society (which wants to encourage the survival of its members in danger, the cooperation of all in saving lives, the advance of medical technology, etc.). Of course, like any other good instinct or habit, it can also ultimately be wrong-headed if followed in all circumstances or to unreasonable extremes.

But the rescue imperative is also a symbolic demonstration of society's values. Rescue efforts say something about both the victim and the rescuer. One cannot imagine the Good Samaritan doing an accounting analysis before helping the man beaten up and left for dead. He does not stop to ask himself whether the man is a worthy candidate for his assistance or too old or too negligent or has too low a quality of life. The parable elucidates certain values (such as spontaneous generosity, a willingness to intervene in crisis, equal respect, the sanctity of human life, concern for the sick and vulnerable) which we wish to promote. Medical rescue acts as a kind of Good Samaritan parable, teaching and confirming these values in the rescuers and the witnesses. Furthermore, rescue can be an expression of mercy, that value which transcends justice without undermining it.

Finally, the rescue-efficiency paradox itself reflects the traditional view that human life is of inestimable value. This does not mean we should spend all our resources on one case of need. But the promotion of this value is perhaps less threatened when the lives which could have been saved (by a more efficient distribution of healthcare resources) are unknown, possible future lives, than when they are immediately in front of us in 'crying need'. The way in which the denial of rescue technologies (such as transplants to children) can result in acute public and professional discomfort, illustrates the need for moral criteria other than simply efficiency by which to judge healthcare allocation.

So I have suggested that there may be good reasons for doing the apparently inefficient in allocating our healthcare resources. There will be times when we have to bow in all humility before the complex and the tragic, in healthcare allocation as elsewhere, rather than imagining there will be a single, simple right and efficient answer.❑