Justice and the Allocation of Scarce Health Resources

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The allocation of scarce health resources implies some way of controlling the supply or purchasing of health care services. There are different models in place in different countries and we recently witnessed a debate in the Unite States over how health care might be managed. The debate took place against a background of probably the least efficient health system in the world, with at least 15.2% of gross domestic product being expended on healthcare compared to 9.2% in Australia, 9.9% in Canada, 7.8 in the United Kingdom, 10.4% in France and 10.8 % in Germany[1]. At the same time standards are no higher in the US and in fact compared to countries such as Canada and Australia which have universal health care systems, the average standard of health of the US population is comparatively lower[2].

Cost and average health standards are a measure of efficiency. They are not necessarily a measure of justice or fairness. One way to measure fairness is to consider the position of the worst-off. Countries with universal systems such as Australia, England, Germany and Canada, however, do well on that score also.

The argument, however, does not stop there with some arguing that justice is more a matter of liberty than the distribution of goods and services such as health care. The concern in that case is that any attempt to achieve equity in delivery of health care services would necessarily violate freedom by requiring government control and restricting those who wish free access to market their goods and services. Liberty always upsets attempts to pattern distribution.

In his encyclical *Caritas in Veritate*, Pope Benedict XVI notes that every society draws up its own system of justice. However he teaches that charity goes beyond justice, because to love is to give, to offer what is "mine" to the other; but it never lacks justice, which prompts us to give the other what is "his", what is due to him by reason of his being or his acting. The Pope went on to say,

> "Justice is the primary way of charity or, in Paul VI's words, "the minimum measure" of it, an integral part of the love "in deed and in truth" (1 Jn 3:18), to which Saint John exhorts us. On the one hand, charity demands justice: recognition and respect for the legitimate rights of individuals and peoples. It strives to build the *earthly city* according to law and justice. On the other hand,

[1] Data from Organisation for Economic Co-operation and Development, *OECD Health Data 2006*, from their Internet subscription database, updated October 10, 2006. See http://www.oecd.org/health/healthdata.
[2] Rudolf Klein, Lessons for (and From) America *American Journal of Public Health* January 2003, Vol 93, No. 1, pp. 61-3

> charity transcends justice and completes it in the logic of giving and forgiving. The *earthly city* is promoted not merely by relationships of rights and duties, but to an even greater and more fundamental extent by relationships of gratuitousness, mercy and communion. Charity always manifests God's love in human relationships as well, it gives theological and salvific value to all commitment for justice in the world."[3]

The delivery of health is services is owed to those who are sick and in need, but their needs also call us to respond not simply out of duty, but out of love. Our first objective in health care then must be to ensure that those in need are humanly cared for. That is not a need for high technology, though technology is certainly a great good, but a need for the warm presence of another who cares and who by their empathy alone can reduce the burden of illness and suffering. That is so because a significant part of suffering because of illness is existential. It is to do with loss of status, capacity, isolation and fear. The only real cure for existential suffering is love. It is a basic requirement of justice that whatever system we have, it must provide at least basic care for those who are in sick and in need.

A frequent question asked in this context is: what is health? A simple answer is to say absence of ill-health or the normal psychosomatic functioning of the organism.

The WHO attempted a definition: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity. "

Many have critcised it for including well-being. "Well-being" equates with happiness and involves much more than is normally meant by health. Well-being includes successful and satisfying exercise of intelligence, awareness, imagination, taste, prudence, good sense, and fellow-feeling[4].

The problems of such a wide definition are inappropriate diagnosis of illness – such that social non-conformity becomes an illness, and the misdirection of health care efforts and over medicalisation and unreal expectations, such as we have seen with the medicalisation of classrooms by over diagnosis of ADHD, the over management and institutionalization of death and dying, and the overuse of anti-biotics.

Healthcare can be defined less controversially as intervention which seeks to restore, maintain, promote health, or to alleviate distressing symptoms of ill-health, and is inclusive of professional intervention and personal health care.

Healthcare happens at several different levels:

- Macro-allocation – what proportion of community resources should be devoted to healthcare

[3] Benedict XVI *Caritas in Veritate* Vatican City 2009

[4] John Kilner *Who Lives? Who Dies? Ethical Criteria in Patient Selection YUP* 1984

- Meso-allocation – what kinds of services should be provided out of these resources
- Micro-allocation – who should get the health services provided

The criticisms of macro-allocation include underspending and misdistribution of needed services, which are demonstrated by queuing. Criticism may also include overspending relative to other social goods such as education, housing, water, nutrition and security. In many parts of the world the greatest barrier to good health is lack of clean water and sanitation. There may also be a concentration in high technology rather than on basic care and on primary care including prevention.

The criticisms of meso-allocation may include overspending on

- Crisis, rescue or acute care
- High tech care
- Institutional care
- Established care rather than research
- Fashionable or traditional rather than alternatives
- Particular regions – city not rural
- Short term and not on chronic
- Areas with media and political clout

Criticisms of micro-allocation may include:

- Unjust discrimination on the basis of a person's age, race, gender, disability or disadvantage
- Overspending on those who are articulate and demanding.

In recent times there has been a trend toward viewing health care in utilitarian terms. Rather than considering the need to private basic care to all those inneed and measuring fairness by the situation of the worst off, utilitarian system judge a system by utility – net sum of benefits and losses in terms of maximizing the average or total utility. To make such judgements there is a need to have a way of measuring the relative utility of proposals.[5]

One such system involves assessing the quality adjusted life years or QALYs. A treatment may then be assigned a value according to predicted quality of life of the patient multiplied by the number of years of life expectancy. The problem with using QALYS is that the judgement about the "quality of life" is problematic and would seem to discriminate against those who are chronically ill or disabled. Someone who is chronically ill does not get better and hence the resources are used simply to maintain them. The score very badly as an inefficient use of resources compared to a well person who only need a short period of treatment to restore health and function.

[5] JJC Smart Ch 4 "An Outline of a System of Utilitarianism Ethics" in Bernard Williams *Utilitarian: for and against CUP 1973*

In the US State of Oregon and attempt was made to ration healthcare on the basis of a psychometric index of quality. The scheme initially attempted to rank conditions and the effects of treatment on a scale of importance. The first attempt was done on the basis of a phone survey and public hearings. There were many anomalies such as:

- Cosmetic surgery ranked as more important than treating an open fracture of the femur
- Teeth repair ranked as more important than treating Hodgkin's disease
- Infertility treatment ranked as more important than obstetric care

In Oregon Phase Two, they tried to categorise treatments in terms of

- Essential Services
- Very Important Services
- Services Valuable to Certain Individuals
- Essential
- Acute fatal, prevents death
- Maternity, neonatal and paediatric
- Chronic fatal – improves well-being
- Contraception, sterilization
- Comfort care – palliation
- Preventive Care – screening

It is worth noting that Oregon was the first US State to legalise physician assisted suicide. One wonders whether that was a result of rationing provoking fear of neglect.

The health care debate over justice often involves a conflict between Fee for Service modals compared to manage care.

Fee for service limits the capacity of governments to ration health care and thus control health expenditure, but it protects the autonomy of health professionals to determine what level of care is appropriate and preserves doctor patient relationship without the interference of another, though the latter can happen through health insurance companies insisting on capping expenditure and placing other limits on the care providde.

Managed care involves the establishment of health maintenance organizations in which individuals enrol and the organization buys services from health care providers. This is a way to achieve effective rationing at macro and meso level. It can involve injustices to particular individuals at micro level, especially the chronically ill and others such as those who have mental illness or cognitive disability, lack the local language, lack family supports, use drug users or are homeless. All of whom involve complications and require more resources to treat.

All systems have problems of fairness. The important issue is the capacity of a system to make adjustments so that no-one is denied basic care and that higher levels of care are allocated on the basis of need. The central fact is that health care is relationship between the provider and the person in need founded by the requirements of justice and the need for love. Funding and allocation systems should protect that human relationship.

As our populations age, there is fear that there will be too few people working to support those who have retired. It is one of the consequences of declining fertility with most Western nations at below replacement level. As the problem increases it is important that we continue to advocate for the needs of the frail elderly and maintain attitudes of respect for them. The commandment that we honour our father and our other has never been so crucial as it is now that economic need requires families to have two incomes and so few are able to care for their ageing relatives. It is a great sadness that so may aged people must rely exclusively on care by strangers. There is a need to make better provision for people who would care for their relatives if the economic circumstances permitted it.