

Is Efficiency Ethical? Resource Issues in Health Care

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Introduction

How can we allocate scarce health care resources justly? What sorts of 'delivery systems' should we have? In particular, are markets the most efficient way to deliver health services? Much blood, sweat and ink has been shed over this issue, but rarely has either faction challenged the unspoken assumption behind the corollary claim made by advocates of markets: that efficiency advances the interests of both individuals and society. That is the ethical firepower which the pro-marketeers have tried to commandeer. Anti-marketeers, whilst contesting the effectiveness of market systems of delivery, have largely accepted the proposition that there is something more than a merely prudential obligation to seek efficiency gains, that efficiency promotes distributive justice by minimizing scarcity of resources. But should the opponents of market systems accept the same criteria as the proponents? Is efficiency ethical?

Whether markets *do* necessarily increase efficiency is arguably a matter for economists, although value questions also enter into this apparently factual debate. But the deeper question is whether efficiency is the correct criterion, in terms of social justice and individual needs. This must be the crux of any discussion about resource allocation in applied ethics.

In this chapter I begin by examining the ethical basis of markets, with particular relation to utility and rights. I argue that no individual is morally or rationally obliged to accept the market criterion of greater efficiency if it disadvantages her. I go on to dissect the basis of markets in political theory, in terms of democratic accountability and fairness. Finally, I ask what other means of resource allocation should be considered, in light of the failure of markets to provide a just and analytically satisfying solution.

Markets and Ethics: Utility and Rights

Efficiency is usually presented as an unimpeachable goal with which everyone can agree. As a British Secretary of State for Health put it, 'We all want greater efficiency, don't we?'¹ But actually efficiency is not everyone's primary aim; nor is it a value-free one. Efficiency is a utilitarian goal, one important corollary of maximizing utility for the greatest number. Utility may be maximized by productive efficiency (the most favourable ratio of inputs to outputs) and allocative efficiency (arranging the societal distribution of resources so as to reward the most productively efficient providers). But why can't we all agree with this aim? Whether it is called utilitarian or not, isn't it one which benefits everybody? Why can't efficiency be morally unexceptionable? If efficient allocation of resources is in the best interests of the greatest number, surely everyone must recognize it as right and just?

The great mistake here is *confusing what I would accept on my own behalf with what I would accept in competition with others*, and after all, markets, which are meant to promote efficiency, posit a Hobbesian war of all against all in which competition is the natural state. There is no supposition of altruism in the invisible hand argument.²

Like the normative basis of markets, the root of this fallacy about efficiency lies in utilitarianism. John Stuart Mill claimed 'that happiness is a good: that each person's happiness is a good to that person, and the general happiness, therefore, a good to the aggregate of all persons'.³ It is the jump from the second to the third premiss that is faulty. In the extreme, it might increase the general happiness of a fascist society for a particular race to be exterminated, and in Mill's syllogism it would therefore be a good to the aggregate of all persons, including the members of that race. Clearly that does not mean that each person's happiness or good will have been increased.

The problem is particularly acute when the good in question is health care. It is not clear how I am supposed to benefit from a system which maximizes efficiency if I am one of those denied treatment in the name of overall utility. Perhaps I would prefer improving family doctor services *for myself* to maintaining acute services at my local hospital, if I had a chronic condition which my general practitioner knew and treated well, if I had several small children with lots of coughs or sneezes, or if I were unfamiliar with Pascal's wager! But it does not follow that I would rationally prefer improved GP services *for you*.⁴

'The utilitarian principle is concerned with the interests of the majority, but justice is concerned with the interests of each person equally.'⁵ A common philosophical argument against utilitarianism is that it disadvantages minorities.⁶ Whatever the merits and demerits of this argument as a general proposition, it has a particular and distinctive force where health issues are concerned. Services for particularly vulnerable groups – the elderly, the men-

tally ill, those with HIV infection or disability, the dying – may well lose out in market forms of health provision. Women are particularly disadvantaged by low resources for the elderly and the mentally ill, so not only minorities suffer under market forms of provision: women form the majority in those groups. All is rarely rosy for non-acute and community services under any system of health-care resource allocation, but one may doubt whether the market will cure disadvantage; it may well worsen it.

This is not the viewpoint of extreme pro-marketeters. In Coase's theorem,⁷ the optimal distribution will naturally occur in a free market, there is no need for either state intervention or reference to rights and entitlements. The pure market automatically produces Pareto optimality, so that no one's lot can be improved without worsening someone else's. A similarly optimal position can only be achieved in rights and contract theories through conscious mechanisms, devices such as the Rawlsian veil of ignorance: there is nothing automatic about it.

If Coase is correct, rights become a commodity like any other. As they say in B-grade detective films, 'Sweetheart, anybody can be bought.' Provided that losers are compensated to some degree, they have no absolute rights, beyond perhaps the implicit initial one to equal concern and respect, the bedrock right in Dworkin.⁸ This is an important right, but it does not play a major part in neo-classical economics. Thus market efficiency is judged in neo-classical economic theories, such as Coase's, *not by what rights it actually harms* – since rights are a useless fiction – *but by what utility maximization it potentially offers*. This appears at first to be a natural extension of Benthamite utilitarianism, which saw rights as 'nonsense on stilts'. Modern utilitarians have been less ready to condemn the concept of rights altogether. Many view the social concept of rights as one which adds value to life and enables society to rub along nicely, giving it indirect utility. Thus principles about rights will score high on 'acceptance-utility', according to Richard Hare. They will be chosen 'on the ground that they are the set of principles whose general acceptance in the society in question will do the best, all told, for the interests of the people in the society considered impartially.'⁹ But for utilitarians there remains nothing particularly remarkable or sacrosanct about rights in themselves: they are at best a convenient fiction which fulfils a social function in our particular society.

However, although they do not regard rights as absolute, market-based theories use the language of rights very freely. The deepest foundations of the ostensibly value-free pro-market outlook are utilitarian, but in a rather confused and contradictory way, the market also embodies contractarian values and harkens back to classic liberal theorists such as Locke in restricting government intervention. Yet the view that rights are a commodity like any other, and not sacrosanct, would be abhorrent to liberals, as would the market philosophy that those who cannot express their wants in price terms have no rights.¹⁰

(Perhaps the upshot of claiming to be value-free is that one merely becomes confused about one's real values.)

Furthermore, neo-classical economics posits 'bargain and contract [as] . . . the natural ordering principle.¹¹ The main form of conflict resolution in the market is negotiation or haggling, the civilized form of Hobbes's 'warre, as if of every man, against every man',¹² rather than administrative *diktat*, as in hierarchies. Meaningful negotiation requires some semblance of equal power. In classical contract theory, individuals in the state of nature are equal in their power to threaten each other's property, particularly property in the person, to kill each other; this is what motivates them to form the social contract. In current civil society there is clearly no such equality.

Markets and Political Theory: Accountability and Distributive Justice

I have argued that market theory is not value-free, but rests on a shaky construction of opposing ethical viewpoints, utilitarianism and contractarianism. Whether the market is efficient is similarly not merely a question of fact, but also of value. It was over both the efficiency and the desirability of market mechanisms that Marx and Weber differed so radically, and their disagreement was not merely the stuff of statistics but also of political theory. Whereas Marx saw market competition as tending unalterably and balefully towards static concentration and monopoly,¹³ Weber presented it as the engine of capitalist dynamism. The market is seen in Weber as a key countervailing power to the state, in Marx as another form of oppression.

These debates are no 'mere' history; as Keynes said, self-styled practical men are usually slaves to some dead theorist.¹⁴ Weber's belief that the top management of socialized or nationalized enterprises inevitably becomes bureaucratic¹⁵ is the intellectual precursor of the proposals in the 1989 UK government white paper *Working for Patients*.¹⁶ Only by injection of mechanisms such as Medical Audit, the Resource Management Initiative and a general NHS management executive, that report implied, could the dead hand of NHS bureaucracy be transformed into the beneficent invisible hand of liberal economics. This was to be done through the creation of an internal market, separating the funding of health care from its provision. Similarly, in Weber the market is seen as a means of democratic accountability, raising an effective barrier against too much power for state officialdom.

But do markets actually empower 'ordinary people' and bestow freedom of choice? Only if they enhance accountability. This requires, first, that information should be decentralized, enabling people to make something approaching a rational decision. In the British system, in practice, patients seem to be getting less information rather than more. This is alleged by some to be deliberate

management policy. According to the British Medical Association, consultants have been ordered by managers not to reveal the lengths of hospital waiting lists or the numbers of patients whom they have contracted to treat in each specialism for each year.¹⁷ Patients no longer have the freedom to choose from any hospital or consultant to whom their family physician recommends them: they will be limited to hospitals with whom their doctor (if a fundholder) or their district health authority holds a contract. None of this looks like greater freedom and accountability: rather, less autonomy and more paternalism – though perhaps from managers rather than medics.

This is largely the case in the more market-led US system, where who gets treatment is effectively decided by health-plan managers, hospital administrators, directors of Health Maintenance Organizations, insurance company executives and officials of companies providing insurance plans or HMO membership to their employees. The decision as to whom *not* to treat is made in the first instance on the basis of who is covered by one of these categories, who is not a player in the market; the rest form the 37 million Americans with no health-care provision. The Clinton proposals would bring this group into the decision-making process, but that process would probably remain managerial rather than popular.

Second, in order for markets to empower individuals, purchasing power must be spread along with information. For example, education vouchers, according to their proponents, would enable the educationally disadvantaged to communicate through price mechanisms. The Clinton proposals for a basic benefit package in an insurance-based system also appear to embody this modified-market approach. But much hinges on exactly how comprehensive the benefit package and the resource allocation turn out to be.

In the UK, patients are *less* free under the internal market to choose where they obtain treatment than they were under the old centralized system. In advocating an internal market the Conservative government stressed the freedom of patients to 'shop around'.¹⁸ In practice a considerable or even greater degree of central allocation remains. The district health authority and budget-holding family doctors receive funding for their patients from central government, and then purchase services prospectively from provider hospitals. If a DHA or a fundholder does not have a contract with a particular hospital, patients can no longer ask to be referred there. Allowing patients to 'shop around' would require their home authorities to reimburse them retrospectively; the UK government has not chosen to grasp this particular nettle. Decisions are not actually made by individual 'customers' in the internal-market NHS: rather by district health authorities and fund-holding general practitioners acting on behalf of patients, paternalistically, and arguably less on the basis of beneficence than of cost-effectiveness.¹⁹

No health-care delivery system will ever abolish paternalism altogether, or achieve the sort of allocation which rational contractors might agree. In health-

care markets there will always be particular reasons why consumers rely unduly on doctors, and perhaps in an even more personal and emotional way on nurses. Patients are uncertain about what treatments are available and how well those treatments will work; lack of information is exacerbated by stress, fear, and the thousand natural shocks that flesh is heir to, but against which the model economic man is immune. In addition, some patients may want to shift the burden of risk-bearing on to the health-care professional,²⁰ although more and more patients now want to take responsibility for their own treatment and to be in a position to give a truly informed consent. (For example, three-quarters of the patients in a recent survey of 262 people seeing a specialist at an out-patients' clinic wanted as much information as possible about their condition, against only 8 per cent who preferred to leave matters in the doctor's hands.²¹)

The problem is that although they are 'sold' as promoting autonomy and rational choice, markets in health care actually increase people's vulnerability rather than lessen it. The Clinton proposals do not alter the fundamentally market-based orientation of the US system, and they have been criticized for exaggerating the two-tier structure, leaving the worse-off still vulnerable. Markets in health care increase the uncertainty and risk for the most vulnerable sectors of the community: children in need of specialist services, or patients in intensive care, where the costs are often greatest for those with the worst outcomes.²² Intensive care unit patients who are later declared 'not for resuscitation' use the most resources of all.²³ As is already occurring in the US under the impact of Diagnosis-Related Groups,²⁴ hospitals in the UK may decide that limiting the quantity of intensive care beds is a better bet than continuing to treat large numbers of high-cost critically ill patients. But productive efficiency is not the criterion by which doctors or patients should judge critical care, I would argue.

It is becoming increasingly clear in the UK that money is not following many of the most critically ill patients, such as children with leukaemia or cystic fibrosis.²⁵ Many district health authorities in the UK have taken the easiest route to market, making block contracts with their local hospitals without taking account of the interests of patients with specialist needs beyond the capacity of the district hospitals. The Clinical Standards Advisory Group, set up by the Department of Health to monitor the internal market, has embarrassed the government by reporting that vulnerable children are indeed disadvantaged by the internal market. The principle of competition between hospitals is largely incompatible with justice for acutely ill patients, the committee held.

This is not merely inefficient allocation of resources, which could be rectified by a more sensitive decision-making procedure. The injustice is inherent in a market approach which sets the highest value on efficiency. In terms of cost-effectiveness, it may well be right for purchasers to minimize administrative

costs and time spent on deciding special cases. But in terms of justice as fairness it is not.

It is difficult to see how anyone in the Rawlsian original position could consent in advance, behind the veil of ignorance, to a system which would discriminate against children with leukaemia or cystic fibrosis. This is so even if one accepts that it may be rational to accept in advance a greater degree of risk that Rawls allows. Rawls's critics have alleged that it could be perfectly prudent to accept a slave system from behind the veil if the rewards of *not* being a slave were sufficient to offset the risk. But Rawlsian contractors are all adults. If I consent in advance to a system in which I may not grow up to become a contractor, a logical absurdity results.

The fact that internal markets in health care allocate resources unjustly does not mean that previous systems of allocation were just, of course. To a certain extent in the US, and to a much greater extent in the UK, doctors have always voluntarily limited use of resources by patients, from the level of the individual general practitioner (family doctor)²⁶ to that of the consultant nephrologist limiting kidney dialysis to the under-65s.²⁷ Life-saving treatment was more strictly rationed for the elderly than for children or neonates, and limited life-enhancing treatments (elective admissions) were ordered more sparingly than life-saving ones. In the mid-1980s, UK doctors were treating far fewer patients for end-stage renal failure than their US counterparts, as well as performing less coronary artery bypass surgery, administering less chemotherapy for tumors they judged unresponsive, and providing fewer referrals to services for the mentally ill and chronically disabled.²⁸ The difference is that markets claim to be giving more choice and greater accountability; the old system never claimed to be anything but paternalistic.

Less facetiously, public accountability under the UK internal market has been undermined by direct elimination of popular representation. (Elected local authorities' rights to appoint some DHA members were abolished in *Working for Patients*.) Acting in concert or even without mutual consent, these new undemocratically constituted authorities can also put hospitals out of action without public consultation. The Tomlinson Report on the future of London's hospitals, meant to take between three to six years to implement, is already being pre-empted by DHAs' decisions not to enter into contracts with 'doomed' hospitals.²⁹

Moreover, even if Londoners who use both hospital and community services heavily – the elderly, for example – were to be 'fully' compensated for the closure of their local hospital by means of equivalent amounts of cash being diverted into GP practices,³⁰ there would still be questions about their rights having been violated. Not only would the way in which the decision was made matter, in terms of democratic accountability; no Londoner could be certain that tomorrow she might not need treatment in the new operating theatre at St Bartholomew's – to be closed down under the Tomlinson proposals – more

urgently than a prescription from her own physician. She might well choose, if she could, to keep the security of greater certainty of treatment in acute cases, matters of life and death. This would be perfectly rational: according to Pascal's wager, a minuscule chance of an infinite loss – as is her death to the individual patient, if not to society as a whole – cancels out a much higher probability of limited gains: treatment for more minor illness by a family doctor. The right to potentially life-saving treatment at a centre of excellence like Bart's cannot be fully compensated by a better level of primary care for chronic or minor illness.³¹

The problem becomes even more acute if the Londoner in this example has only infrequent contact with her own doctor, but does have an immediate and urgent need for the operation at Bart's. Why should she accept the decision to close the operating theatre as just and fair, if it hurts her? As I argued in the first section, no individual is obliged to accept an allocation of resources which disadvantages her, in the name of majority interests.

In this second section I have argued that the interests of the majority are also threatened by market mechanisms, or more precisely, that the market undermines democratic accountability, which is designed to ensure that majority interests *are* served.

Alternative Forms of Resource Allocation

Advocates of the internal market might reply that health needs are a bottomless pit, and that no one's rights are absolute, since demands for health care can be infinitely expandable. If this is so, some form of rationing is inevitable. Of course the *particular* forms of rationing which we are now experiencing are not really inevitable, merely the product of a higher governmental priority on funding other areas than health. But this does not obviate the need for theories of resource allocation, and the market does not have a monopoly there.

Arguments based on rationality or efficiency alone can't get there from here, as it were. Although extreme advocates of pure markets such as Coase claim that moral concepts like rights are superfluous, it is impossible to explain why any individual should accept allocation by market principles, utilitarian dicta about efficiency, or any other distributive mechanism without invoking some theory of justice, entitlements and the social good. Indeed, I have tried to argue that the proponents of the market must acknowledge their own theoretical ancestors, although a cynical wit might doubt whether their pedigree was entirely on the right side of the blanket. In that bloodline there is a certain amount of miscegenation between contract theory and utilitarianism.

Several contending criteria for allocating scarce health care resources³² have been offered by medical ethicists and political philosophers:

- 1 *Clinical criteria*, subdivided into:
 - (a) *Prognosis*: the resource should go to those with the best chance of recovery (of utilizing the input with maximum productive efficiency);
 - (b) *Diagnosis*: the resource should go to those whose clinical need is the most acute, even if their chances of recovery are not great.
- 2 *Social criteria*, subdivided into:
 - (a) *Past merit* or 'social worth';
 - (b) *Future merit* or 'potential contribution'.
- 3 *Equality*: everyone should be treated equally in deciding how to share out the resource, regardless of need or merit, and certainly regardless of ability to pay. This criterion leads to a policy of randomizing allocation, or, less stringently, to allocating resources on a first-come-first-served basis.

In the discussion which follows I shall treat both subdivisions of clinical criteria together, although in emotive terms they pack very different punches. The recent death of 5-year-old Laura Davis, born with short-bowel syndrome, whose prognosis was never anything but poor, illustrates the popular appeal of allocating resource according to need rather than chance of recovery. Those in greatest medical need of a resource by *diagnosis* may well not be the most savable in terms of *prognosis*. This relates to the issue of triage, which will be discussed at greater length when I come to social criteria.

The appeal of a 'purely' clinical set of criteria is that it supposedly bypasses subjective moral considerations and produces an impersonal form of distributive justice. Like the utilitarian calculus to which it is philosophically indebted, it claims to be objective. Some subjectivity may enter in through devices such as 'quality-adjusted life years' (QALYs), or the telephone polling by which members of the Oregon public were asked to rate the importance of various medical procedures for Medicare funding. But broadly speaking, the clinical model interprets the Aristotelian dictum on justice (treating likes alike) by treating as likes those potential recipients 'who are equal with respect to exterior, observable, therapy-related criteria. The criteria are applied unwaveringly and damn the implications for general equality.'³³

Why should there be any implications for general equality? Surely medical need is blind, and decision according to medical need impartial? Unfortunately not: models of allocation according to medical need have been shown in several separate studies to disadvantage patients of the 'wrong' class, race or sex.

The class point is the easiest to see. In a case at the Churchill Hospital in Oxford, the dialysis treatment of Derek Spence, a vagrant kidney patient, was terminated because he was judged not to be fully *compos mentis*, and therefore unable to follow the diet and other requirements for successful treatment. There was considerable conflict over the decision between nurses, who wanted to continue dialysis despite the patient's abusive manner towards them, and

physicians, who viewed treatment as a waste of resources. (It has been alleged that medical criteria for allocation generally discriminate against the mentally ill.³⁴)

This was a case of ending treatment rather than deciding not to initiate it, and might be judged to require higher standards (though not by all commentators, many of whom maintain that there is little ethical difference between terminating care and not offering it in the first place³⁵). But the 1986 American case of Baby Jesse illustrates a decision not to initiate treatment, on supposedly clinical justifications which turned out to have an unwitting class bias.

Baby Jesse was a potential heart transplant candidate who met the preliminary criteria on medical grounds. But his parents, unmarried teenagers with a criminal history and drug abuse problems, were judged unlikely to provide the necessary follow-up for the cardiac transplant, such as punctual administration of immunosuppressive medications. The clinicians who rejected Baby Jesse as a transplant candidate were accused of discriminating on social grounds, though they maintained that they were allocating the extremely scarce resource of infant hearts according to purely medical criteria.³⁶

Furthermore, it turns out – through one of luck's little ironies – that a purely medical set of criteria for organ allocation benefits whites disproportionately. Histocompatibility makes a successful graft more likely, and for that reason the US Task Force on Organ Transplantation used a criterion for transplants of a six-HLA antigen match and no mismatches.³⁷ But it is more difficult to obtain six antigen matches in Afro-Caribbeans: statistically, whites are more readily typed by tissue match. Medical advisability is not a straightforward criterion which can eliminate the quirks of chance and avoid questions of justice.

This point emerges most strongly in relation to gender. A study of 87 US treatment centres for end-stage renal failure found that three out of four patients selected for dialysis were male.³⁸ Ninety-two per cent of those treated were white, but although very slightly disproportionate to the 88 per cent of the population who were Caucasian, this figure was nothing like as skewed as the male–female ratio. All but eight of these centres used mainly 'medical' criteria, and allowed doctors to decide without reference to a lay committee or any other body. This gender bias is all the harder to believe given that women's longer life span means that more potential life-years can be gained by preferring a woman patient to a man of the same age and prognosis. Since women are much more prone to urinary tract infection, which can produce chronic renal failure, there is little reason to think that men made up three out of every four patients who presented with end-stage renal failure. Whether consciously or unconsciously, doctors deciding on the primary basis of 'medical need' were in fact preferring men over women.

This begins to merge into a discussion of social criteria. Even decisions made on ostensibly medical grounds are usually coloured to some extent by social considerations, consciously or unconsciously (as in the case of Derek Spence).

In the study of the 87 centres, which revealed that three-quarters of the scarce resource of dialysis was given to under half of the population (men), leaving the decision up to physicians was actually no guarantee that clinical criteria would predominate. Some centres admitted to administering IQ tests and personality inventories, perhaps trying to add a spurious scientificism to 'gut reactions'.

A related issue in social criteria for resource allocation is triage. The classic example of triage embodied conflict over justice and distribution within the medical profession: between the medical officer in charge of the US North African forces in World War II and a consultant surgeon, over whether scarce penicillin should be given to venereal disease sufferers rather than to men wounded in battle, on the efficiency grounds that the VD victims could be more quickly returned to active service. That the VD victims won out goes against our intuitive sense that those honourably wounded in battle merited the scarce resource more. Deciding in their favour would have been on the grounds of *past merit* or social worth. But the VD sufferers could make a *future contribution* more readily, with less input of scarce medical resource.

The most famous and open use of social criteria was by the Seattle 'God' Committee. In the 1960s Dr Belding Scribner, who had developed a semi-permanent shunt which enabled patients to be dialysed repeatedly without successive surgery, established a secret committee of seven laypersons and physicians to ration use of what was then an expensive and innovative technique. Preliminary 'medical' guidelines increased the proportion of those rejected for dialysis from one in fifty to one in four, although many of those clinical criteria, as is their wont, were actually highly arbitrary. (No children were accepted, for example, and no patients over 45.) Patients deemed psychologically incapable of coping with the treatment regime were also ruled out.

This left three out of four candidates to be considered for 'social worth'. No criminals or prostitutes were treated; college education, church membership, civic leadership, and high earning capacity all counted in a patient's favour. The members of the committee were rarely in doubt over who was most socially worthy: the clerical representative said, 'Oddly enough, in the choices I have made the correct decision appeared quite clear to me in each case.'³⁹ The labour leader stated that he gave preference to religious candidates with large families.

Just because social values do often enter surreptitiously into clinical criteria does not mean that we should legitimize them in the operations of such a committee.⁴⁰ But many people who would accept that proposition may none the less feel that curtailing health care for the very old is justifiable on the grounds of their minimal *potential contribution* to society. Whereas past merit is unacceptable to almost everyone, many people accept future merit as having some bearing. But should they?

Physicians and nurses owe no less a duty of care to elderly patients than to neonates, but the cost of maintaining the elderly is high. In a time of growing

numbers of elderly people and stable or declining spending, we may expect to see an increase in the use of potential contribution as a criterion for rationing scarce resources. As previously 'extraordinary measures' of life support become ordinary, as the interval between terminal diagnosis and death lengthens, 'the death-avoiding therapies . . . can become like food, a kind of medical sustenance the withdrawal of which leads unfailingly to early death'.⁴¹ Further, if we accept curtailing resources for those who can no longer contribute to society, we should be all the more disposed towards cutting short the lives of those who will never be able to contribute much in conventional terms: handicapped neonates, for example.

So far there is, happily, little indication of any such developments in health-care law. Although some commentators wrongly regarded it as opening the floodgates to mass euthanasia of the 'unfit', the *Bland* decision⁴² of 1993 in the UK actually went the other way: regarding nasogastric feeding tubes not as ordinary nursing care, but as an extraordinary medical intervention. Nor was Tony Bland's inability to contribute to society so long as he lay in a persistent vegetative state an issue in the case. The resource issue has weighed more heavily in similar US decisions, since the cost of maintaining the patient must often be borne by the family there (unless it is covered by Medicaid or insurance). But US case law is actually more restrictive than *Bland* in so far as it requires evidence of what the PVS victim would have wanted.⁴³

If clinical criteria are unable to remain purely objective, still less, of course, can social criteria for allocation of scarce health care resources escape being ethical judgements. Only the criterion of *equality* overtly recognizes ethical considerations, tackling them head-on through the assertion of equal rights inhering in all patients simply by virtue of their common humanity. Even medical criteria deny this premiss; but after all, people do not choose to be ill (though they may sometimes choose behaviours that lead statistically to illness). Therefore even those with a poor prognosis are victims of discrimination if denied life-sustaining resources in favour of someone with a better clinical outlook. 'Why, after all, should their shorter lives be measured against lives that would have been longer from no merit of their own?'⁴⁴ Clinical merit is as much conferred by chance as is social merit, this radical egalitarian argument runs.

The Seattle 'God' Committee members stated that they would have felt irresponsible if they had resorted to a lottery for choosing dialysis recipients. But in legal-ethical terms, lotteries have been held fairer than social criteria when there is conflict of life with life. In *US v. Holmes* (1841), the presiding judge ruled that a surviving crew member, Holmes, should not have collaborated with his shipmates in devising and implementing social criteria for deciding who among a shipwreck's survivors should be thrown off a lifeboat in order to lighten its load. Despite his counsel's contention that the crew's method of selection – 'not to part man and wife, and not to throw over any woman' – was more humane than a lottery, Holmes was convicted of unlawful

homicide. In the judge's opinion, only casting lots would have been a remedy which the law could sanction: 'In no other way than this or some like way are those having equal rights put on an equal footing, and in no other way is it possible to guard against partiality and oppression, violence and conflict.'⁴⁵ Holmes and his shipmates failed to achieve the most efficient or meritorious allocation, in any case: two women jumped overboard to die with their brother.

In this century, several medical ethicists have proposed a modified form of randomized allocation, usually after some debatable elimination through medical criteria of those patients with little or no chance of recovery.⁴⁶ What makes this retention of some clinical judgement debatable, of course, is the element of uncertainty in prognosis, of subjectivity in clinical criteria, and of possible benefit to even a terminal patient of a few extra days in which to finish unfinished business. (Indeed, one medical ethicist is willing to give *greater* weight to the desire for life in the patient with a shorter expectation of it.⁴⁷) Thus Rawls writes,

[W]hen there are many equally strong claims which if taken together exceed what can be granted, some fair plan should be adopted so that all are equitably considered. In simple cases of claims to goods that are indivisible or fixed in number, some rotation or lottery scheme may be the fair solution when the number of equally valid claims is too great.⁴⁸

But could a lottery system ever be practical? A new genetically engineered drug to treat multiple sclerosis, betasteron, is being distributed in the USA through a nationwide lottery involving a waiting list of 57,000 patients. Medical criteria are used initially to restrict eligibility for the lottery: patients must be able to walk at least 100 yards and must have the relapsing-remitting form of the disease. A tracking system guards against attempts by wealthy patients to buy extra lottery tickets. 'Most of my patients are accepting the wait pretty well', commented one neurologist, 'because there is an element of fairness in a lottery'.⁴⁹

As markets publicize resource shortfall and encourage referrals on the 'buy now and avoid the rush principle', however, lotteries tend to attract attention.⁵⁰ If it became known that hospitals were allocating life and death on a random basis, through a lottery or first-come-first-served procedure, fewer people might bequeath their kidneys, feeling that their gift of potential life was not being treated with due gravity and gratitude.

Conversely, however, power-holders might do their damndest to lessen scarcity of medical resources if they had to take their chances in a lottery, rather than being favoured by decision procedures based consciously or unconsciously on social merit. Lotteries have the virtue of putting pressure on authorities to allocate more resource, whereas acceptance of medical or social criteria effectively blames the patient for failure to receive the scarce resource. In 1953 the UK Ministry of Health instituted a national lottery by birth date to allocate

what was then the scarce resource of polio vaccine. Many families were able to vaccinate some of their children but not others. The resultant public outcry helped to make the vaccine more widely available.⁵¹

Elsewhere I have argued that we need to make some exceptions to the principle of randomisation.⁵² First, in cases where the scarce resource is nurse time, we must consider the nurse as an autonomous moral agent who can experience regret and remorse. She is not at all the same as an ampoule of penicillin, and we must think about how to respect her as well as the patient. Starting from the principle of equality is generally correct, but the applications are sometimes startling. For example, nurses normally prioritize dying elderly patients on general wards over less acute cases.⁵³ A dying patient gets more than an equal share of the nurse's scarce time. I think this is right and proper, although it certainly fails the clinical criterion of favourable prognosis or the social one of future contribution, and it invades the egalitarian principle of randomness.

The second area in which exceptions might be argued is the choice between giving the resource to a 70-year-old or a 20-year-old. Most people find the answer obvious enough, but on the whole I am inclined to say they should have equal chances. (I would not agree that the 70-year-old has a *greater* right.) Both may have an equal desire to live, although admittedly that is not the only factor which we have to consider. There is also the good of living beyond 20, and the distress to the younger person's family. But this second argument, about family bereavement, is clearly wrong. We would not say that a 20-year-old with no family should have a lesser claim to the resource than a 20-year-old with hordes of adoring kin.

The good of living beyond 20 is a pricklier issue. In Veatch's view justice as fairness demands,

that persons be given an opportunity to have well-being over a lifetime equal to that of others. This means that infants, who have had no opportunity for well-being, would get a higher priority than older persons who have had many good years of life.⁵⁴

But what if the years have not been good, or are just becoming so? The fact that people in modern western societies *do* normally live to a statistical average of 70 (longer for women, though this is not taken into account by those who would ration resources by age) says nothing at all about whether they *should* live beyond 70. To argue otherwise is a form of the naturalistic fallacy, the common assumption that something that is natural is also morally right. To put the matter in Rawlsian terms, youth is not a form of desert any more than is intelligence or class.

The third exception to random allocation might be the case of a patient with dependants. Here duty rather than desert is the issue, and the need of others rather than their bereavement. In the case of a mother with young children, Jonathan Glover, though favouring random allocation in many cases, acknowl-

edges that 'refusal to depart from random choice when knowledge about their dependants is available is to place no value on avoiding the additional misery caused to the children if the mother is not the one saved.'⁵⁵

John Harris feels that Glover's preference for saving those with dependants is a form of discrimination favouring parents. '[T]his looks very much like a covert grading of people into the "haves" and the "have-nots" – those who have dependants and those who don't.'⁵⁶ Harris even speculates that people might 'acquire' children in order to benefit from 'a relatively cheap form of insurance against a low-priority rating in the rescue stakes'. But having children is extremely expensive, particularly for women, in terms of lost earnings. Nor are children merely a possession, as Harris implies. I would make exceptions to random allocation of scarce resources for mothers and some fathers of dependent children, and for women and some men over 45, the even larger group of carers for elderly or handicapped relatives.

Although markets claim to be both objective and fair, I have argued that they are neither. Allocation by the egalitarian principle of randomization best meets the deontological criterion of respect for persons. Even some consequentialists agree that the fallibility of the utilitarian calculus in life-and-death matters makes random selection the fairest procedure.⁵⁷ Although lotteries are not rational in their operations, they are profoundly just.

NOTES

- 1 Virginia Bottomley, London, March 1993.
- 2 For an interesting reformulation of economic theory to incorporate altruism, see David Collard, *Altruism and Economy: a Study in Non-Selfish Economics*.
- 3 John Stuart Mill, *Utilitarianism* cited in Anne Haydock, 'QALYs – a threat', p. 185.
- 4 A similar argument is made in relation to QALYs (quality-adjusted life years) by John Harris in 'QALYfying the value of life'.
- 5 Downie, 'Traditional medical ethics and economics in health care', p. 51.
- 6 The best-known version of this criticism is probably that made by John Rawls in *A Theory of Justice*.
- 7 Coase, 'The problem of social cost'.
- 8 Dworkin, *Taking Rights Seriously*. 'In practice economists recommend policies which are only *potential* Pareto improvements. Most economists view actual compensation as irrelevant to optimality' (Hanly, 'The problem of social cost', 1992, p. 80, original emphasis).
- 9 Hare, *Moral Thinking: Its Levels, Method and Point*, p. 156.
- 10 For a useful stylized comparison of the normative bases of markets, hierarchies and networks, see Walter W. Powell, 'Neither market nor hierarchy', table 1.
- 11 E. Miller, 'Economic efficiency', at p. 722, cited in Hanly, 'Problem of social cost', p. 82.
- 12 Thomas Hobbes, *Leviathan*, Part I, ch. 13.
- 13 For interpretations of Marx's theory of concentration of production and the resulting crises of capitalism, see: Held, *Models of Democracy*, pp. 111–12; Sweezy, *The Theory of*

- Capitalist Development*; Mattick, *Marx and Keynes*; and Fine and Harris, *Rereading Capital*.
- 14 Keynes, *The General Theory of Employment, Interest and Money*, ch. 24, v.
 - 15 Weber, *Economy and Society*, vol. II, p. 1402.
 - 16 HMSO, *Working for Patients*. The 'provider market' in *Working for Patients* is of course only one type of market, in one sector of the economy (the public one) and my discussion does not pre-empt the question of how efficient other types of market may be.
 - 17 Mihill, 'Waiting list facts "denied to patients"'. Northwick Park Hospital in Middlesex wrote to its consultants, 'Patients should . . . never be given information about districts and contracting, and GPs should only be given information on these grounds where absolutely necessary.'
 - 18 This was somewhat different from the 'market socialism' form of internal market envisaged by A. C. Enthoven, who popularized the term 'internal market' in his 1985 paper *Reflections on the Management of the National Health Service*.
 - 19 For further discussion of these two types of reimbursement and the corresponding 'type 1' and 'type 2' forms of the internal market, see Penelope M. Mullen, 'The NHS White Paper and internal markets', p. 19.
 - 20 Mooney and McGuire, 'Economics and medical ethics in health care', p. 8.
 - 21 *Which?* magazine, survey by the Consumers' Association, 7 February 1991.
 - 22 Seitovsky, 'The high cost of dying'. See also Coulton, 'Resource limits and allocation in critical care', p. 88.
 - 23 Younger, Lewandowski, McClish *et al.*, 'The incidence and implications of DNR orders in a medical intensive care unit'.
 - 24 DRGs were introduced by the Reagan administration in 1983 to control Medicare and Medicaid costs by changing payment from retrospective to prospective. The amount paid to hospitals in advance of services rendered is specified by the classification of the patient's illness into one of 467 diagnosis-related groups.
 - 25 This was the conclusion of the Clinical Standards Advisory Group, established in 1991 by the Department of Health as a panel of doctors considering four types of specialist services: neonatal intensive care, cystic fibrosis treatment, care of childhood leukaemia sufferers, and coronary bypass surgery (Mihill, 'NHS policy changes "put patients at risk"').
 - 26 Raanan Gillon, in 'Ethics, economics and general practice', gives many specific examples of this self-restraint.
 - 27 Challah, Wing, Bauer, Morris and Shroeder, 'Negative selection of patients for dialysis and transplantation in the UK'. In this study, a questionnaire containing sixteen case histories of patients with end-stage renal failure was sent to a large number of British and American GPs, consultants and specialist nephrologists for their opinion on the appropriateness of dialysis or transplantation. The UK GPs and consultants rejected a significantly higher number of cases than did the UK nephrologists, although even they rejected a mean of 4.7 cases, against 0.3 for US nephrologists.
 - 28 Aaron and Schwartz, *The Painful Prescription: Rationing Hospital Care*.
 - 29 Sheldon, 'London HAs jump the ministerial gun'.
 - 30 Of course this would be highly problematic: to start, we would also have to weigh in the costs of the 30,000 staff whose jobs are at risk from the London health changes, according to a secret brief allegedly produced by the Department of Health and leaked by the Confederation of Health Service Employees (Travis, 'Hospitals must wait to know fate').

- John and Gillian Yudkin, respectively a professor of medicine and a GP, argue further that 'acute hospital beds are merely one of the places where people end up when all else fails . . . [T]here is an overall deficit of 1.6 beds per 1,000 population in inner London, perhaps explaining why most hospitals are on yellow alert and why GPs are having to use the Emergency Bed Service even before the Tomlinson Report is implemented: acute hospital beds are serving a function which is not being provided elsewhere' (letter to the *Guardian*, 21 January 1993).
- 31 For a similar point in a different context, see Guido Calabresi and Philip Bobbitt, *Tragic Choices*, p. 84.
 - 32 This is what Calabresi and Bobbitt term the 'second-order' question of how to distribute the resource, rather than the 'first-order' determination of how much of it to produce or allocate in the first place (*Tragic Choices*, p. 19).
 - 33 *Ibid.*, p. 184.
 - 34 Pattison and Armitage, 'An ethical analysis of the policies of British community and hospital care for mentally ill people'.
 - 35 The viewpoint of the twenty doctors, nurses, lawyers, ethicists and health-care administrators who produced the Hastings Center, *Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying*; see p. 130.
 - 36 Veatch, *Death, Dying and the Biological Revolution*, pp. 208-9.
 - 37 US Task Force on Organ Transplantation, *Organ Transplantation: Issues and Recommendations*, p. 87.
 - 38 Katz and Procter, *Social-psychological Characteristics of Patients Receiving Hemodialysis Treatment*, reported in Winslow, *Triage and Justice*, p. 16.
 - 39 Winslow, *Triage and Justice*, p. 15.
 - 40 For the opposite argument, see Leo Shatin, 'Medical care and the social worth of a man'.
 - 41 Baumrin, 'Putting them out on the ice: curtailing care of the elderly', p. 155.
 - 42 *Airedale NHS Trust v. Bland*, Law Lords' decision of 4 February 1993, reported in the *Guardian*, 5 February 1993.
 - 43 For example, in the 1990 case of Nancy Cruzan, another PVS victim, the US Supreme Court required 'clear and convincing evidence' of previous statements by the victim concerning withdrawal of life support in the event of an accident.
 - 44 Calabresi and Bobbitt, *Tragic Choices*, p. 182.
 - 45 *US v. Holmes*, 26 Fed. Cas. 360 (1841).
 - 46 For example, Veatch (*Death, Dying*, p. 206) thinks that 'people in equal need of an organ ought to have an equal shot at it even if one potential recipient would be more likely to make a socially worthwhile contribution'. Other scholars have proposed some form of randomization in allocating scarce resources, usually either a lottery or a system of first-come-first served; their works include: Winslow, *Triage and Justice*; Paul A. Freund, 'Introduction', *Daedalus*, spring 1969, p. xiii; Childress, 'Who shall live when not all can live?' Outka, 'Social justice and equal access to health care'; Green, 'Health care and justice in contract theory perspective', pp. 111-26; and Dickenson, *Moral Luck in Medical Ethics and Practical Politics*. Most of these texts concern issues around transplantation, but I also extend the principle of equality through randomization to the allocation of nurse time (in my 'Nurse time as a scarce health care resource').
 - 47 Harris, *The Value of Life*, p. 89.
 - 48 Rawls, *A Theory of Justice*, p. 374.
 - 49 Martin Walker, 'Luck of the draw for MS drug', *Guardian*, 8 January 1994.

- 50 Calabresi and Bobbitt, *Tragic Choices*, p. 189.
 51 Hinds, 'On the relations of medical triage to world famine', pp. 38–9.
 52 Dickenson, *Moral Luck in Medical Ethics*, p. 64ff.
 53 See Veatch and Fry, *Case Studies in Nursing Ethics*, case 23, 'Allocating nursing time according to benefit', p. 84ff.
 54 Veatch, *Death, Dying and the Biological Revolution*, pp. 204–5.
 55 Glover, *Causing Death and Saving Lives*, p. 222.
 56 Harris, *The Value of Life*, p. 105.
 57 See, for example, Glover, *Causing Death and Saving Lives*, pp. 218 and 223.

READING GUIDE

Typically the problem of scarce resources is treated as part of the general question of distributive justice by philosophers. Several standard works in medical ethics include chapters under that or a similar title. Utilitarian reasoning is applied in Jonathan Glover's *Causing Death and Saving Lives* and to a lesser extent in John Harris's *The Value of Life*. Both Glover and Harris offer some surprising prescriptions, particularly in relation to rationing by age, although Harris backtracks somewhat to what he calls a 'fair innings' argument.

Largely deontological accounts of distributive justice include the appropriate chapters in Thomas Beauchamp and James Childress, *Principles of Biomedical Ethics* (3rd edition, 1989); Donna Dickenson, *Moral Luck in Medical Ethics and Practical Politics*; and Robert M. Veatch, *Death, Dying and the Biological Revolution*. This last source also illustrates the overlap between distributive justice and the literature on euthanasia and termination of care. Issues about rationing of scarce resources impact on prolonging life when there is little hope of cure.

Health economics tends to take rationing as a proven requirement, in a way that philosophers do not (or at least should not, I would argue). A more philosophical introduction to health economics can be found in chapter 17 of Robin Downie and Kenneth Calman's *Healthy Respect*.

Specific issues within health-care resource allocation frequently come to the fore, attract considerable media attention, and then lapse again into obscurity. In the past particular scrutiny has been paid to kidney transplants, out of all proportion to the number of cases. Issues around arbitrary procedures for deciding on who gets resuscitation, far more important in numerical terms, are now beginning to attract more attention, particularly in relation to recent findings that people with AIDS are more likely to be pressured not to choose resuscitation than are other patients with less stigmatizing illnesses.

An incisive exploration of issues of gender, race and class discrimination in access to health care can be found in Susan Sherwin's *No Longer Patient: Feminist Ethics and Health Care*, chapter 11.