

What Would be the Rational and Logical Process to Managing and Providing Health Care Delivery System on a Moral and Fair Basis, Considering that Resources are Limited?

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ABSTRACT— *Is it morally acceptable for a publicly funded healthcare system to purchase non-life prolonging treatments (for instance, Viagra), whilst simultaneously limiting access to potentially life-prolonging treatments (for instance, Beta Interferon)? This begs for one of the most pressing contemporary questions in the healthcare, which is how do we distribute resources fairly? Questions such as who should be treated and how priorities should be set raise fundamental ethical dilemmas that have long been at the centre of healthcare around the world. Now that 'rationing' is more visible, or at least more openly debated, than in the past, the ways in which decisions are made are in the healthcare about treatment and management of illnesses are more likely to be contested and challenged. This article explore resource allocation (bearing in mind that allocation poses an ethical problem because the resources to be allocated are scarce), examines key concepts such as Quality Adjusted Life Years (QALY's), utilitarianism and theories of justice (the central principle in this discussion) offer different guidance on how to provide comprehensive and optimal healthcare on a 'just,' fair and moral basis.*

Keywords— Resource allocation in the healthcare

1. INTRODUCTION

Medical treatment has become more effective in providing cures for life threatening conditions, consequently the demands on health services have increased in line with peoples' enhanced expectations of what should be provided (Buchanan, 2007). In the current situation of scarcity of health care resources (Baker, 2015), there is a need to assign a rationing of some sort to different healthcare deliveries and activities, which may reflect the importance attach to health and illnesses. The factors likely to affect this rationing may vary across communities, individual and times. But even if we agreed on all the important factors, which should go into decisions about which health care activities to fund, we would still need to explain the *relative* importance of each of these factors. The issue for exploration in this article represent one of the difficult choices that healthcare practitioners have to make about the allocation of scarce resources and therefore focuses on decision-making, deciding which patient will obtain particular treatment or service because only a limited amount of resources are available.

2. RESOURCE ALLOCATION

No resources are infinite, even if the basic material is widely available, the cost of manufacturing, treating or assembling it, put some restraint on its use; in addition, the manpower required for distribution and exploitation of the finished product is always going to be limited (Daniels & Sabin, 2015). Applying this to healthcare delivery, it is clear that it is impossible to provide every form of therapy for everyone, therefore some sort of selective rationing may be inevitable. Cost of healthcare is rising while the world faces persistent economic difficulties. The average span of life is increasing and, as a result, people need treatment for longer; this treatment is not the 'easy-cure' type appropriate to infectious diseases but is rather a matter of sophisticated care for the results of degenerative changes. In addition, the public are better informed on medical conditions and are better able to assimilate the information they are given; the choice of treatment is also increasingly influenced by the patient's demands, with proportionate erosion of the doctor's

discretion, in effect, while the latter may wish to treat on a productivity basis, the former views therapy in terms of feasibility.

A compromise must be achieved between demand and supply, if the health services will meet the need of the general public. The distribution of scarce resources poses some of the more complex ethical problems of modern medicine that permeates every aspect of its structure. Objectivity may no longer be the main arbiter and is replaced by need, itself described as an imprecise and elastic concept, and in the event of 'enforced rationalisation' the assessment of relative need dictates a value judgement. How then is that judgement to be made? In practice, many decisions are made instinctively and without the need for profound analysis, thus, the single-handed doctor, for example, may un-hesitantly choose the patient in greater pain for treatment, despite the fact that this will simultaneously delay the treatment of those in lesser pain. There may well be moral arguments against such a decision, for example, though the circumstances are acute and, the urgency being comparable, the doctor has selected a single criterion on which to base the judgement. However, the practitioner conscience may be locked in the 'prison' of rational justification for equity and fairness. Hence, can healthcare practitioner ensure that resources available to healthcare are allocated fairly, equally and on a moral basis? Can the '*principle of justice*' help healthcare practitioner judgements with fairness and equity in the delivery of healthcare provision?

3. JUSTICE

It is imperative to explore the meaning and practical implications of justice in the health care provision. The word justice is used in a variety of different ways, all of which are legitimate, and can lay claim to being the true meaning of the word (Gillion, 2014). However, it is possible to identify the principal meanings of the concept of justice: first, the concept of justice as retribution or punishment; and second, the concept of justice as fairness, and in particular fair distribution (Edwards, 2012). The first notion of justice as retribution or punishment is of more relevance to discussions about law rather than health. For it is concerned with the idea that those who do wrong should be brought to justice. That is to say, that the wrongdoing may be offence against a man-made-law and called a crime is punishable by society through the judiciary system. This notion of justice has little to do with health care, though there have been, and probably still are, examples of health care workers using their 'power' to punish those whom they believe to have done wrong in terms of 'dos' and 'do not' for example, in dialysis unit (Edwards, 2012).

The second idea related to justice is that of justice as fairness. It is this idea of justice that is of primary interest in this article. It is sometimes described as the justice of distribution, that is, the justice (or fairness) of the distribution of commodity to each individual in an equal portions. Seedhouse (2011:23) suggests that there are three versions of justice as fairness: "to each according to his rights, to each according to what he deserves, and to each according to his need." One interpretation of 'to each according to his rights' is that it implies some sort of contract. If I do something for you, then I can expect something in return. If we apply this idea to healthcare, then we might argue that there is a contractual arrangement between the healthcare professional and the patient, in other words, when a person seeks health care he or she enters into a contract with the healthcare worker and becomes a patient. The doctor, having agreed to 'take on' the patient, offers to treat them. It could then be argued that in return for the promise to treat, the doctor has a right to expect the patient's compliance.

Does the patient also have rights under the contract? In a public funded health care system, it could be argued that the patient is paying, through taxation or national insurance and therefore, has a right to expect a return for this money. The contract then is not with the individual healthcare worker, but with the health services. However, there is a wider and more significant interpretation of the notion 'to each according to his rights'. It is derived from the idea that fairness is about equality. The notion then comes to mean that each individual has equal rights, in other words, we all have the same rights to health care. If the idea 'to each according to his right' is not interpreted in this way, but is seen purely in contractual terms, then there are basic, built-in injustices. However, equal rights do not automatically give rise to equal returns, to say therefore, that justice in health care is about equal rights to it, will not automatically ensure equality of distribution.

What then of the notion 'to each according to what he deserves?' This implies the idea that health care has to be earned. It is the notion which lies behind everyday sayings such as, 'You get out of life what you put in'. It can be argued that those who have the ability and means to enhance their health, but fail to do so from choice, lose some of their rights to health care. Should the person who chooses an unhealthy life-style be entitled to receive the same healthcare as someone who makes every effort to maintain their health? This question poses fundamental problems. First, where do one start and stop the argument? Do you refuse to treat an attempted suicide, or the woman who hemorrhages following an illegal abortion? The list could be endless, especially in this current climate of global financial downturn, when most of the major causes of mortality in our society can be attributed, at least in part, to the individual's behaviour (Rumbold, 1999).

Second, while there might be an overwhelming statistical probability that a smoker's lung cancer is due to smoking, there is always the slim chance that it might be coincidental (Gillion, 2014).

Although the ideas of justice as 'to each according to his rights' and 'to each according to what he deserves' may have some applicability to health care, they do not seem totally to meet an ideal notion of fairness in health care. What then of the third idea: 'to each according to his needs'? Is this more likely to provide a firmer basis for rational and logical fairness in the provision and delivery of healthcare services? And will this be able to give answer to the title of this article? What becomes apparent in the healthcare organisations around the world, is that injustice in health care is inevitable if resourcing is insufficient to meet all needs, therefore what measures can be morally and justifiably used to bring about the most just distribution of those resources? Can Quality Adjusted Life Years (QALYs) provide the answer?

4. QUALITY ADJUSTED LIFE YEARS (QALYS)

QALY's aims to assess the difference in quality of life between individuals (Johnstone, 1989). QALYs are used as a measure for apportioning health care at both macro and micro levels. QALY's has been explained as a means of measuring the relative value of one health state over another (Johnstone, 1989). As a measure, it brings together changes in survival, morbidity and quality of life. It provides a way of comparing the cost, not just in financial terms, of quite distinctly different procedures and/or health problems. According to Johnstone (1989) the essence of QALYs is that it takes a year of healthy life expectancy to be worth **1 (one)**, but regards a year of unhealthy life experience as worth less than **1 (one)**. Its precise value is less the worse the quality of life of the 'unhealthy person'. This is sometimes referred to as the healthy-death scale, because death has the score of zero.

According to Seedhouse (2011), the first weakness of QALYs is that only a limited number of criteria are used to measure quality of life. The second is that it is possible for an individual to attain a negative score; that is, to be worse than dead. Despite those criticisms, would the allocation of health care resources on the basis of QALYs be just? The idea is that those who score high should receive priority, and of course, the cost of treating them will be less than those with lower scores. In other words, those who are less debilitated, have a greater chance of survival and whose future life is likely to be of a 'better quality' should receive priority in the allocation of resources. There seems to be a certain illogicality in the statement above, for what in effect is being said is that the less ill you are, the greater your entitlement to health care. In essence, the problem which faces the individual practitioner is the same as that which faces any government or Health Authority. They have insufficient resources to meet either demand or need and therefore health care system has to prioritise. In effect, what may determine choice, is immediacy of need. The needs of a patient whose condition is life-threatening are more acute than those of a patient with a non-life-threatening condition. Equally, the need of a patient for a bedpan may be more immediate than the need of the patient who wants to discuss her anxieties. But, of course, not all choices are as straightforward as these. On the other hand, should some characteristics or factors be considered as morally significant in deciding who and why an individual may get treatments and the other denied treatment? factors such as individual need, the likely outcome and cost of treatment, and perhaps, in some cases age, sex, and employment status, for example?

5. UTILITARIANISM

I will revisit the theories of justice approach as discussed earlier in this article. Will the theories of justice offer any useful guidance on the best way to rationalise healthcare resources? Or what type of treatments (non-life prolonging or life prolonging treatments) should take a priority in the healthcare organisations? I will begin with a utilitarianism approach. Utilitarianism is simply explained as 'the greatest good for the greatest number', therefore the allocation of health care should be carried out in a way that ensures the best outcome, in other words, that maximizes benefit or utility. As Beauchamp and Childress observed (2002), this approach to justice involves trade-offs and balances, as public and private benefits are compared, cost savings are predicted and, risks and probability of failure are assessed. It also means that more emphasis is placed on basic health care and public health measures (such as disease prevention) because these are the most socially useful and cost-effective. They are socially useful in the sense that they are more likely to prevent future costly illness and are also more likely to generate the most beneficial 'returns' for society. Given the utilitarian's concern to use funds in a way which helps the most people, resources would have to be channelled into treating the most common and least costly diseases. This could inevitably result in expensive or rare conditions being given low priority. Not surprisingly, the utilitarianism approach has been criticized in the literature. First, it would almost certainly mean that the young could get preferential treatment, given that their health and well-being is most likely in the long term to be in society's interests in employment as well as in other terms (Edwards, 2012:107). It could also mean that certain groups, such as those with a stigmatising or rare illness or those who are not socially valued, could be excluded (Kopelman, 1995:209). Second, the problem for all utilitarians is not only the impracticality of accurately predicting the

consequences of health-related actions but also of calculating what is best for the greatest number, given that the concept of health itself is such an elastic concept (Buchanan, 2007).

Having explored the concepts of justice, I will like to examine the likely practical implications of the theories of justice. Providing health care to those who need it seems, at least initially, to be the simplest and most preferred way of allocating scarce resources. Not only does it reflect the commitments made by the government (Mason & McCall Smith, 1999), that every citizen has the right to receive health care on the basis of clinical need but it also corresponds with what many regard as the basic function of the health services, namely to provide equal access to health care for those in equal need (Mason & McCall Smith, 1999). Yet despite frequent use of the term ‘need’ and widespread acceptance that it may be one of the necessary criteria for the fair allocation of resources, its meaning in practical sense is far from clear (Gillon, 2014). Thus, if a very broad definition is adopted for the purpose of this article, for example, then a person can be said to need something if without it s/he will be harmed or detrimentally affected (Beauchamp & Childress, 2002:329), then the term is so expansive that it becomes difficult to distinguish need from desire, demand or mere wants. Furthermore, just as perceptions of illness, health and disease (which are subjective concepts) vary from one person to person and from time to time, so too are our perceptions of need culturally and socially determined.

Another difficulty is, as Baker (2015) points out, that there are two different models for the determination of need: the market conception of patient or consumer demand and the professional conception of expert determined health care need. If the patient led model is adopted, then whatever patients demand and believe, they have a legitimate right to claim it, be it cosmetic surgery, viagra (non-life prolonging treatments) and can be construed as an unmet need if it is not satisfied. But neither is the professional conception of need any more precise, not least because, as new treatments, services, knowledge and technology become available so do practitioners perceptions of need change and invariably expand.

6. CONCLUSION

In concluding, it is worth pointing out that the task of defining need is made no easier if, as some suggest, the government’s role should be limited to satisfying peoples’ basic health needs, since this raises the question as to what counts as basic (Beauchamp & Childress, 2002). Few would accept that only life threatening conditions should be included, but where would the line be drawn? In particular, would it inevitably include treatment for conditions say, hip replacements or purchase of viagra that, while not life threatening, are nevertheless life enhancing? In addition, perhaps one of the biggest problems of all with a need-based approach is noted by Gillon (2014:96) “what happens when there are too many ‘needy’ (life threatening) patients chasing the same scarce resources? How choices should be made between these competing patients? Who, in other words, should get priority?” Should we reject moral evaluation of patients as a general basis of choice and rationing in the healthcare? Daniels and Sabin (2015) have emphasised the importance of the process by which resources allocation decisions are made. They argue that for decisions to be just, rational, moral and logical the process by which the decisions are made, must be multi-dimensional and this may include the severity of the illness and availability of resources. One feature of such a process is what Daniels and Sabin (2015) call a ‘relevance condition’ that is the rationale for a decision must rest on medical evidence, reasons and principles that all fair-minded people can agree are relevant, when deciding resource allocation in the management of the health services.

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