

## Priorities, Justice and the CORE

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The debate about what should constitute core health and disability support services in New Zealand is being taken to a second stage by the publication of two further documents. *Best of Health 2* has been produced by the Core Services Committee to follow up on its earlier publication, *Best of Health*. This sequel repeats the points made about the need to prioritise in view of limited resources and then goes on to define four questions that need to be answered about a specific intervention in order to take the debate further. These questions are: "what are the benefits?"; "is it value for money?"; "is it fair?"; and "is it consistent with the community's values and priorities?"

The third question - "is it fair?" - is more fully explored in a second publication of the Committee, to be distributed at the same time as *The Best of Health 2*. This document consists of three papers commissioned from the Bioethics Research Centre (written by myself and Grant Gillett), plus a discussion of these papers by David Seedhouse of Auckland Medical School. The general title of this publication is *Ethical Issues in Defining Core Services* and the specific issues dealt with are "Justice and the right to health Care", "Defining Effectiveness and Benefit" and "Autonomy revisited". The commentary by David Seedhouse concentrates on both problems of definition and problems of obtaining genuinely democratic decisions in this complex and vexed area.

### Defining fairness

So how are we to determine what is fair? *Best of Health 2* argues that we must consider individual benefit to a particular person at a particular time. It thereby rejects a "lists" approach, which would either include or exclude services, without regard to individual circumstances. It also rejects the Oregon idea of producing a priority list of interventions related to specific conditions. Instead the Committee favours broad guidelines regarding effective interventions for specific conditions which would apply in 80%

of cases and which clinicians would be required to apply. (Room would also be left for departing from the guidelines in specific instances, provided a specific case could be made.) Parallel with this the Committee believes that there should be the elimination of interventions which are of no demonstrable benefit, plus a gradual shift of resources within and between services according to the differences in marginal benefits to be gained by such shifts. In summary, we may see the proposals as cautious, "piecemeal engineering", which will bring savings in resources and shifts in allocations only gradually, and following extensive consultation with professionals and with the community.

This broad approach seems to gain backing from the document discussing the theoretical background to the

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debate. After surveying various theories of distributive justice, Grant Gillett and I found a modified form of Rawls' account to be the most adequate. This stresses the priority of the liberty principle, adapting it to health care by requiring that health care interventions equalise the opportunity to exercise freedom. To achieve this, special attention needs to be paid to the health care needs of disadvantaged groups.

However, it is a long step from this general principle of justice to determining priorities through assessing effectiveness and relative benefit. The stress on fairness to individuals preempts the QALY method of assessing benefit, since its aggregate approach discounts individual benefit. Yet some combination of quality and quantity measures seems inevitable, in order to discriminate fairly between the claims on resources of different individuals and groups. The suggestions of Norman Daniels (Just Health Care) and

of a Dutch working party (Choices in Health Care) point in the direction of restoration of the ability to participate in community life as a general measure of basic entitlement to health care. Using this measure, some ranking of different interventions and support methods might be attempted. But the hazard of ranking, as the Oregon experience has demonstrated, is that it fails to set a minimum level of entitlement leaving it to the vagaries of budget setting to determine the cut-off level.

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### A rich concept of autonomy

These considerations drive us to a deeper level of social philosophy, forcing us to ask (as David Seedhouse observes in his commentary) what kind of society we want. This question is prior to considerations of control of public spending. In the third paper, "Autonomy Revisited" an attempt is made to articulate this by means of a "rich" account of autonomy. This is based partly on the Kantian notion of a "rational kingdom of ends", but, more importantly for New Zealand, on the Maori conception of the interweaving of individual and community. Such a view of autonomy sees both professional and business autonomy as hazards to just health care. Equally the stress on individual self-interest (often confused with autonomy) leads to a society in which only the strong are free. In a society which sees the health of all its members as a communal responsibility, the autonomy of each will be seen as a treasure which all must guard. If this is our shared value (and Seedhouse suggests that careful research is needed to find this out) then the "core" will be what this term implies - an essential and irreducible centre without which there is no just health care.

### In conclusion

These then are the main points of the new discussion papers. As an author of one of them, it would not be appropriate for me to offer a critique, but perhaps I may set them in a wider context. The New Zealand debate is one which is echoed in many other countries with developed health care systems. All are asking the same questions about limiting provision to meet finite resources in as fair a manner as possible. However, the core debate in New Zealand has some unique features. Few, if any, countries have attempted so ambitious a debate. Our Health Minister is required to hear the advice of the committee (though not necessarily to follow it), and this advice is based on both expert opinion and public consultation. The Committee has released documents which put the theoretical issues into the public arena and it will be running workshops (with assistance from the Bioethics Centre) on these issues to involve a selection of different groups from high school pupils to the elderly and with attention to cultural diversity. Although Oregon attempted public consultation and the Netherlands government sought Bioethics input for *Choices in Health Care*, these have been passing phenomena. The Dutch Report has not been adopted by the Government, and the Oregon experiment remains locked in controversy. (In the USA as a whole, we await the conclusions of Hillary Clinton's marathon consultation!) In the UK the government has kept its distance from any debate of the ethics of resource allocation, leaving it to the regional authorities to work out their own salvation as best they may.

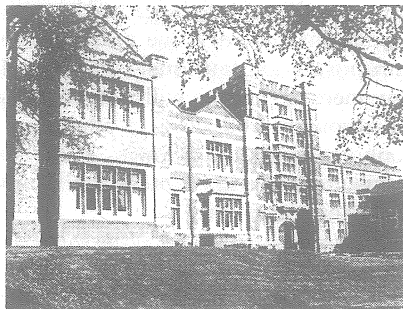
Thus, whatever the limitations of these documents, it seems that they nonetheless hold a unique place, as ethical guidance for both communal consultation and government decisionmaking. This puts New Zealand in a leading position. One may hope that, whatever Government holds power after this year's election, this notable attempt to bring the ethics of health care into the public arena will be continued. The "core" may be something of a Holy Grail, but is surely nonetheless a quest worth pursuing.

**Note:** Copies of the papers referred to above may be obtained from the Core Services Committee, PO Box 5013, Wellington.

## INTERNATIONAL SEMINAR ON BIOETHICS

**P**lanning for the Centre's International Seminar on Bioethics, which takes place at Knox College in November, is well underway and the provisional programme is now available.

The first half of the week will concentrate on clinical and research issues while the second will focus on priorities in health care. It will be possible to register for the whole week or for either segment.



Sessions have been planned in a variety of formats ranging from lectures to "hypotheticals". The latter involves the presentation of a series of hypothetical case studies to a panel who then give comment. The Centre has run hypotheticals on a variety of topics, as lunchtime forums, and they have attracted a lot of interest. There will also be workshops, small discussion groups, two slots for the presentation of research papers and even some sightseeing time!

Eighteen board members of the International Association of Bioethics are now confirmed to speak, and there will also be a strong New Zealand presence with speakers representing, among others, nurses, patient advocates and hospital management.

After the registration and welcome on Monday 22 November the first sessions get underway in the afternoon. There will be two sessions running concurrently - one on Coma, Dying and Death discussing such issues as the withdrawal of treatment in comatose patients, euthanasia, and refusing life saving treatment. The other, Genetic Research, will focus on the ethical issues which arise out of mapping the human genome.

Tuesday begins with another choice of sessions for registrants. Assisted Reproductive Technology (a look at the questions surrounding the growth of treatments for infertility) and Research and Impaired Consent (what principles should apply when patients, for whatever reason, are unable to give informed consent to research?). The sessions will be followed by workshops on the same topics.

Later in the day there will be two "hypothetical" sessions. One is titled Perinatal, how far should we go to save lives of children with severe birth crises possibly leading to multiple disabilities? The other concerns the ethical questions surrounding the treatment of AIDS and STDs.

The Seminar then breaks into small discussion groups, followed by an opportunity for participants to present research papers. The president of the IAB board, Peter Singer, will give a public lecture that evening on Animal Rights.

The final sessions of the first segment take place on Wednesday 24 November. Again there will be two concurrent sessions with one taking the form of a debate on Ethics Committees - are they needed and are they effective? The other is a "hypothetical" on Psychiatric Illness.

A workshop on Feminist Approaches to Ethics will follow.

The afternoon sees the beginning of the second segment which focuses on prioritising in health. The first session in this half of the week will be a slightly more informal one, a symposium on Ethics in a Multicultural Context. In the evening Irihapeti Ramsden will give a public lecture on Maori Health Issues.

Thursday begins with Markets, Standards and Rationing of Health Care. What ethical principles should operate in professional standard setting and discipline, and should these apply to administrators as well as to traditional health care professionals?