

## Prioritisation and Maximisation: Drawing the Ethical Line

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### Background

Most participants in the Health Policy debate agree that there is an essentially limited budget available to meet a potentially unlimited demand for health services. It is against this shortfall that the idea of 'Booking Systems' for elective procedures was first mooted (Fraser, Alley et al. 1993). An unfortunate legacy of this original proposal was the suggestion of a dual criterion for rationing, namely need *and* ability to benefit. The exact definitions of these terms were not discussed but it was commented that such 'enquiry is essentially ethical in nature' and it was recommended that the Core Services Committee facilitate exploration of these matters (ibid p28). The result of this recommendation has been the development and implementation of the National Waiting Time Project (NWTP). This project has proceeded largely independent of any ethical evaluation. When, partially in response to public disquiet and concern within the HFA, an ethical report on the progress of the NWTP was commissioned the authors found a disturbing legacy of this originally vague proposal (Evans and Price 1999).

### A Tale of Two Rationing Strategies

In a situation where there is a limited budget but a potentially limitless demand for services two principles of allocation can be proposed:

1. Services should be offered to those who have the greatest need.
2. Services should be offered to those who will achieve the greatest benefit.

These two statements reflect the principles contained in the idea that rationing should occur on the basis of need (statement one) and capacity to benefit (statement two). At a glance this seems perfectly reasonable and not so much of an issue as to warrant a paper in a highly respected Bioethics Report. Some exploration of the difference between these statements is warranted.

The nature of a health need is a matter

of elaborate philosophical reflection (Sheaff 1996). An important, though not sufficient, determinant of a need is the demonstration of some form of benefit. If I can not obtain any benefit from a service it is senseless to speak of my need for it. This does not mean that the degree of need is proportional to this capacity to benefit. For example, a patient with Chronic Obstructive Airways Disease who is house bound and now needs oxygen therapy will show little benefit, they will still be house bound. Their need, however, is immense. Without the oxygen they will be sitting still gasping for breath feeling that they are about to die: a situation of great need for something to be done. With the oxygen they will be sitting still, breathing through a mask: little comparative benefit.

Therefore we can conclude the need and capacity to benefit though related are not mutually substitutable ideas inasmuch as the degree of one is not proportional to the degree of the other.

This illustrates the difference between the two rationing statements above. Statement one is a representation of the principle of prioritisation. Statement two represents maximisation. It is these two principles that will be examined in this paper.

### Maximisation

The idea of a maximisation policy is as old as John Stuart Mill's *Utilitarianism* (Mill 1910). The problems faced by attempts at maximisation are the same as those faced by his original proposal. Utility theories rely on the identification of goods and then an action that will maximise the achievement of these goods. The limitation that plagued Mill and continues to plague utility theorists today is this identification. Mill's answer to this lay in a panel of experts who had tasted all types of happiness and could therefore identify and rank all happinesses. This has been described as 'a conceptual impossibility illustrated, for example, by the need to taste both the joys of fidelity in marriage and infidelity'. (Evans and Price 1999 p18) This *conceptual impossibility*

forms the basis of the most important critique of maximisation based health policy.

The form of maximisation health policy that was most heavily critiqued in Evans and Price was the QALY and its derivatives. This was because it is a prominent theory and also one that the HFA has considered using for purchasing decisions in New Zealand.

The identification and ranking of goods that is the first step in the implementation of any maximisation policy is particularly difficult in health care. Most modern theories of medical ethics realise that the identification of a successful outcome can only be done by the individual patient. This has given rise to the major emphasis in clinical ethics being placed on autonomy. It makes little sense against this background to attempt to develop systems that decide on a population basis what are the greatest benefits to be gained from medical intervention. Many more sophisticated maximisation theories attempt to allow for greater sensitivity of differences between population subgroups etc. What must be realised is that this will never allow for correction of this criticism until everyone's opinion has been gathered and taken into account. Such a process would be impossible. One popular example is the issue of fertility; many people present to their doctor to have infertility induced and this provides a benefit. Others present to have their infertility ameliorated. How would we identify the benefit to be maximised here?

These same problems apply to the aggregation and ranking of goods once identified. Does the treatment of one couple's infertility rate as a greater good than the 'treatment' of another couple's fertility? How do we rank pain? Is it a greater good to treat one terrible pain or two moderate pains?

The next problem that troubled Mill and troubles modern critics of utility is the issue of equity or justice. Just because we can demonstrate a sum gain in utility does that make a course of action *right*? Perhaps the most graphic

example of this is the Christians and the lions analogy (Gillett 1989). If a large enough group of Romans gain a large enough pleasure from watching a Christian being fed to the lions, does that make it right? In health care if we can gain a greater benefit by treating those with early stage disease, is it right to leave those with more developed disease without treatment?

No matter how sophisticated the system to measure these becomes, it is a *conceptual impossibility* to truly perform this analysis. There is no 'panel of experts'. We cannot compare different pains. There is no way to put a 'justice modifier' into the equation to create a just outcome from a system that is inherently unable to produce justice. The danger with sophisticated maximisation tools is that they appear to address these limitations through large sample sizes and non-disease specific variables. This creates the potential for injustices to occur through their implementation. Utility or cost benefit analysis can be useful in informing decision makers. The constant danger is that the decisions will be made solely by these useful tools. This is heightened by the refined, sophisticated tools because of the appearance of having taken everything into account.

### Prioritisation

Prioritisation aims to treat those with the greatest need first. This policy would enhance equity. If equity is defined in terms of access, it fulfils this by giving those with the greatest need access to services. If equity is defined in terms of outcome, treating the most needy moves their health status towards that of the least needy, thus approximating equity of outcome. It does not rely on the maximisation of outcomes, however, but rather a move towards a more equitable one.

Such a process is in keeping with what Prof. Campbell found to be the attitudes of New Zealanders he studied. He found that the

critterion of distributive justice most firmly endorsed was that of distribution according to need. This meant that resources could be unequally distributed so that the outcome is the same – so that everyone has the chance to 'survive' equally (Campbell 1994 p9).

This statement also reflects the principle of John Rawls' *Theory of Justice*, one of the most influential modern theories of its kind (Rawls 1971 cited in Evans and Price 1999 p17).

The requirements for a prioritisation system include tools for assessing need.

There are a number of potential difficulties in establishing a nationally consistent prioritisation system. Most of these are practical matters. It is obvious that it will be difficult to establish nationally acceptable protocols for prioritising specific services. It is not impossible. These protocols should simply be national consensus documents on how to identify which patients have the greatest need for a service. Such ranking has always been done by clinicians but in an *ad hoc* and individual way. The requirements of prioritisation demand an explicit and consistent means of doing this.<sup>1</sup>

The other problem with prioritisation is the introduction of so called horizontal equity. This is the notion that it would be possible to use priority scores for different services in order to ration resources between services. Such an approach founders on many of the difficulties that maximisation policies do, namely the conceptual impossibility of comparing unlikes. It is not a valid comparison to decide between someone who really needs a hip replacement (score 87) and someone who really needs their cataracts done (score 92). Such a move, though favoured by the HFA (Prioritisation Team HFA 1998 cited in Evans and Price 1999), would not be acceptable ethically due to the concerns discussed above. An additional potential pitfall is finding the distinction between the ethically desirable vertical equity (prioritisation within a service) and the ethically unacceptable horizontal equity. In other words, what should be defined as a service? Is ophthalmology a 'service' within which all patients can be prioritised? Or must there be prioritisation between cataract patients and glaucoma patients separately (and all the other types of elective patients clinicians see)? This question can only be answered by clinical staff. For only they have the knowledge of the disease states to judge if meaningful comparisons of need can occur between them.

### Conclusion

The Evans and Price report examined both practical and conceptual hurdles faced by the developing NWTP. The focus of this paper has been to address one of the conceptual hurdles. What is the ethically preferable principle by which to ration health care? The report did not examine which principle would be easiest, most practical or

least restrictive of clinical autonomy. From this brief analysis it is possible to form a few conclusions.

Any attempt to maximise health benefit through the use of non-disease specific maximisation tools is doomed to fail, because

- a) it is a conceptual impossibility to compare such unlikes as individual human suffering;
- b) it is unlikely, except by coincidence, that any such rationing decisions would be just.

Prioritisation according to need is in line with documented values of New Zealanders and modern justice theory.

Prioritisation faces many difficulties, one of which is the important conceptual problem of the distinction between vertical and horizontal equity.

These difficulties must be addressed by all those involved in the development and implementation of the NWTP. An important facet of the future development should be ongoing ethical scrutiny in order to prevent injustices and ease public concern.

### Notes

- <sup>1</sup> Granted this is a simplification but the focus of this paper is on the difference between maximisation and prioritisation. Discussion of the details of either must occur elsewhere. For an overview see Evans and Price 1999.

### References

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