Debate

Resource allocation: a plea for a touch of realism

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Author's abstract

The problem of resource allocation in health has stimulated much thought and research, in attempts to provide objective, rational methods by which necessary choices can be made. One such method was proposed in a paper in this journal (1). The authors argued for a utilitarian approach, which they claimed to demonstrate was acceptable to society at large.

This paper argues that the evidence supporting such a claim was flawed; such a utilitarian approach is not socially acceptable, and is therefore not relevant. Rather more relevant directions for research are discussed, based on the assertion that a degree of realism is essential when considering the problems of resource allocation.

In their recent paper, Lewis and Charny (1) present data from the Cardiff Health Survey, which they suggest support their hypothesis that 'society' would be prepared to choose, on the basis of age, between two individuals requiring treatment, in situations where resources allow the treatment of only one. The data are the choices which respondents would make between pairs of patients of different ages, each of whom was suffering from 'leukaemia', but 'only one [of whom] can be treated'. The interviewer was allowed to encourage the respondent to choose if he/she initially could not do so.

The apparent conclusion from Lewis and Charny's paper is that society at large adopts a utilitarian approach to the distribution of health resources, and that if only sufficient data could be amassed, it ought to be possible to embody this societal view in some sort of model which would allow doctors to translate society's apparent wishes into clinical practice. They believe they have found a way of bringing 'true democracy into health service decision-making'.

In his reply to their paper, Lamb (2) discusses many of the dangers of, and difficulties with, such a public opinion survey approach. In doing so, he takes 'the relevance of [the] questions, [and] interpretation of

responses' in the original paper 'for granted'. In failing to discuss the relevance and interpretation of Lewis and Charny's results, however, Lamb legitimises their conclusions, and shifts the discussion to specific problems which these conclusions raise; for example, which criteria should and should not be used to discriminate; how much weight should be attached to opinions arising from prejudicial attitudes etc.

I will argue, however, that Lewis and Charny's data, and their interpretation of them, are largely irrelevant. This can be seen by closer examination of an issue raised in both papers (1,2), that of the difficulties of social distance (see below). Consideration of this problem also allows insight into areas where research may be of relevance in guiding those who fund and allocate health services.

In an earlier paper, Almond (3) argues that for today's moral philosophers – whose work, as at no other time, has direct, practical applications – it is essential that the question be asked: 'Is what I propose to say likely to be useful or helpful to those currently confronting this problem personally?' In other words, are the theoretical conclusions being formed going to have any *relevance* in the real world? To satisfy this, moral philosophers must frame their discussions around axioms derived from the real world. In this way, a theoretical solution to, for example, the specific dilemma concerning the use of aborted fetal tissue for transplantation, can only be *relevant* if it accepts the fact of the availability of aborted fetal tissue, under certain socially sanctioned conditions.

Almond's question is not of importance because it might prevent disastrous philosophies from adversely influencing real events; this she deals with differently. What such a question seeks to do is to establish *relevance* to theoretical discussions, such that the conclusions reached may actually *be able* to influence events in the real world.

In order to establish the irrelevance of Lewis and Charny's data, it is therefore not necessary to concentrate on specific flaws. Instead, examination of the very basis of their survey indicates that it fails to have social relevance, and therefore that their conclusions are not applicable to the real world.

The key lies in the problem of social distance. Lamb (2) reminds us that preferences indicated in the context

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of an interview (ie an abstract situation), may be completely revised when the social distance is decreased, for example in the context of the actual illness of a loved one. Such *concrete* situations are likely to evoke a very different response, namely that the treatment of the loved one should be undertaken whilst it is personally and medically desirable to do so, regardless of his or her age. Lewis and Charny acknowledge such difficulties, but dismiss them by citing 'a wide discrepancy between the optimum solution to a problem in terms of society as a whole and from the perspective of an individual'.

This concept is that of the 'greater good' (1). One must assume that if utilitarian health policies along the lines suggested by Lewis and Charny were to be instituted, a significant proportion of the individuals who comprise society would suffer at the hands of these policies every day. Their concerns and protests are deemed to be subordinate to the 'greater good' of society as a whole, which would 'benefit' by more individuals being alive and healthier per unit cost, as a result of discrimination. If, as Lewis and Charny's paper might suggest, society does hold such a utilitarian view of 'greater good', then their findings may satisfy Almond's question, and may well have social relevance. It is my contention that this is not the case.

Consider what actually happens when a respondent who, in the abstract situation indicated that he would choose a five-year-old over a 70-year-old for treatment, is faced with the prospect of his previously healthy father being refused curative treatment because he cannot compete in terms of 'worth' with another, younger patient. The respondent is likely, as Lamb (2) points out, to reverse his previous preference, but probably only as far as to say that he thinks his parent too, is *worthy* of treatment. He may well still accept that compared with a five-year-old, the parent's utilitarian 'worth' is minimal, but factors other than utilitarianism are coming into play – notions of justice and compassion, and the worth of human beings in terms of parameters other than years of life to lose, investment by society, etc.

In this situation, Lewis and Charny's original criteria still stand, in terms of age of the two patients (or indeed their 'sex, social class, marital status etc' (1)) – so we must ask what has changed to alter the respondent's opinion, now that the social distance has been so drastically reduced? The answer is that the respondent now questions Lewis and Charny's original axiom, that *only one of the two patients can be treated*. Thus whilst the respondent may not have questioned the conditions originally set upon his response in the theoretical situation, once the situation becomes a *reality*, we find that Lewis and Charny have failed to frame their research around axioms derived from this respondent's real world.

But does this finding call into question the idea of the 'greater good' being a utilitarian one? After all, Lewis and Charny have recognised that individual

perspectives would be offended, and have dismissed the importance of this (1). One must only look at, for example, the vast amount of charity and voluntary work which goes on in our society to realise that motivations such as justice and compassion also play their part. It seems likely that philosophies which compete with utilitarianism and which were originally 'dormant' in our hypothetical respondent, would likewise be aroused in other members of society were utilitarian discrimination to be proposed.

Other writers in the field provide good reviews of such philosophies (for example 3,4,5,6). The fact that we do care for the severely handicapped, recidivists, the chronically mentally and physically ill, refugees, not to mention 'dumb animals', all at considerable expense, points to the fact that society does not view the 'greater good' in purely utilitarian terms, but in fact in terms of a complex mixture of competing philosophies. Thus whilst society does seek the wise spending of its resources, it also has notions of its responsibilities to its members, and these responsibilities can only be met through the expenditure of resources.

These observations must call into serious question the validity of the pre-conditions which were set upon the Cardiff Health Survey questions, in terms of their ability to describe the real world where people do fall ill, and where people are valued for more than just their 'utilitarian worth'. What Lewis and Charny have done is to construct an hypothesis which contains a debatable principle, and then to couch specific questions to test it. Unfortunately, these questions do not test the debatable principle itself, but merely explore its possible applications. Far from them then being able to argue that the effects of social distance are irrelevant because they have shown that 'society' as a whole supports their hypothesis, the reason they *have* data to support their hypothesis is precisely *because* of the effect of social distance in preventing the questioning of this original principle, ie that out of two fatally ill patients, only one *can* be treated.

So what would constitute relevant research in this field? Almond (3) discusses two approaches to the marriage of ethics and medical practice. One is the definition of broad ethical principles from which to draw practical conclusions. Thus researchers should be examining what principles people *do* use in considering the right of an individual to treatment or not. Given what has been discussed above about social distance, these principles must be examined directly. Elucidation of these principles, and the ways in which they interact, might allow the identification of realistic practical solutions to specific problems, which may not necessarily involve discrimination.

The second approach which Almond describes is the use of the detail of practical instances to arrive at broad principles. We need to know how large are the 'large numbers of physicians working in isolation' who today apparently make decisions about who to treat and who not to, on the basis of limited resources (1). In what

fields are they working; who is discriminated against? From the knowledge of such detail can principles as to the acceptability of these practices be discussed.

Information is also required as to the current uses of resources. Are there areas of medicine where money could be saved without damaging patient care? Do we duplicate our activities unnecessarily and therefore waste money? Increasing emphasis on audit is starting to provide some of these answers. It is only when we have such practical details that we can decide what problems really exist, and whether alternative strategies can be employed to prevent deterioration in patient care, other than the adoption of planned selective deterioration of care for certain groups of patients.

Finally, and most fundamentally, just who is promoting, as Lamb puts it, 'an atmosphere of increasing reluctance to finance escalating health costs'? It is by no means clear that 'society' as a whole shares the reluctance of those who hold the central purse-strings. 'True democracy' in terms of deciding levels of resources may be a first step to take, before examining strategies for their distribution.

Similarly, it is the expansion and improvement of medical technology which is cited as being partly responsible for escalating costs. In some fields at least, striving for improved medical technology is the equivalent of finding better, more expensive ways of trying to shut the stable door, after the horse has bolted: the root causes of many health problems are more amenable to social improvements rather than medical ones (7,8,9,10).

I have suggested that Lewis and Charny's results and interpretations are irrelevant because, by virtue of their simplicity, they would not help those facing such choices in the real world, a world where human behaviour and values are determined by much more

complex principles than pure utilitarianism. I therefore make a plea for a touch of realism to enter the field. If strategies are launched upon society which are not socially acceptable, then I do not fear the legitimisation of discrimination against patients on the basis of age, sex, social class or marital status etc: I fear for politicians and planners who will be out of their jobs.

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