

Letters

Resource allocation – what is the first priority?

SIR

There are many ways of tackling the problem of how to prioritise the allocation of health care resources. One can side-step the issue altogether (as politicians seem to be remarkably adept at doing) as the British health ministers have done by giving the General Practitioner (GP) a budget which means that all such tough decisions of fair distribution are in the local doctor's hands. Alternatively one could flood the health system with funds (which unfortunately politicians aren't so adept at doing) such that the question is effectively abrogated. However, both these solutions avoid reality. Health is not a finite concept whereas budgets are, and therefore the problems posed by economic restraints are inescapable. Today the question is out from beneath the proverbial carpet as daily doctors are having to decide who does and who does not get treatment. In other words today's GP is deciding who lives and who dies.

Let us look at the alternative theories available for deciding how to distribute health care resources:

(i) **Laissez faire:** First come first served. This has the advantage of avoiding all sorts of value judgements as to what is worth providing and who gets treatment, as these decisions are determined by chance. This kind of concept is consistent with the nature of ill-health itself, which strikes in random fashion in time, place and person. However, if this concept is taken to its own logically consistent extreme then it is possible that eventually hospitals will run out of their allocated funds such that all health services will have to be closed

for the second half of each financial year!

(ii) **The lottery:** As with laissez faire this system avoids the need to make any value judgements. Perhaps then doctors should add dice to their pockets along with their stethoscopes?

(iii) **The leader:** One could of course appoint a 'Resource Allocator' who could make unquestionable rules. But who are we to appoint to lead such a dictatorship?

(iv) **Learned decisions:** This is a utilitarian concept where the cost-effectiveness of health care is studied, such that learned decisions can be made in the setting of priorities for resources allocation in the health-care system with the aim of producing the most health for the most people. This necessarily involves making value judgements about what is valuable in life within the parameters of health care. Unfortunately such judgements are based on the assumption that it is possible to 'QALYfy' the value of life and they can be unfairly discriminatory, as argued by Harris (1). However, I do not believe that such criticisms are insurmountable. This utilitarian policy may have an Orwellian flavour but it does not necessarily follow that an '*Animal Farm*' or a '*1984*' will emerge.

As already stated – lives are at stake daily. Let us choose, as making a decision is really the FIRST priority. Can one accept: (i) the bizarre consequences of a laissez faire approach; (ii) that life and death decisions can be entrusted to the toss of dice; (iii) that one man's value judgement is just as just as the next man's and is to be followed blindly? I believe that these three alternatives are morally irresponsible and that in fact the only morally responsible thing to do is to bite the bullet, make some kind of decision about what is and what is not

worthwhile, recognise the potential adverse side-effects and minimise them accordingly.

I can see no other alternative, so let us turn to the real questions to be answered. What is cost-effective in health care? What is worthwhile providing? What is valuable in life, and what parts thereof are relevant to health care (and this is another question)? Are QALYs a fair assessment, as suggested by Williams (2) and propounded by Cubbon (3)? Is public opinion of any moral significance in this kind of decision as argued by Lewis and Charney (4) and Goodman (5)? Are Langford's modified egalitarian principles appropriate (6)? Black (7) believes that doctors are the ideal decision-makers, is this right? (I wonder what kind of value judgements my GP down the road is making?)

I suggest that an approach analogous to that taken by Britain in deciding on the ethical problems raised by new technology in embryo research should be taken. Are not lives at stake? Are not the problems of the National Health Service (NHS) in Britain, 'A Question of Life' (8)? Thus I propose that the value judgements required in order to allocate health care resources as fairly as possible should be formed subject to the scrutiny that a public enquiry entails. At least that way Black's colleagues will be given some guidance on how to make such tough decisions. These value judgements need to be made by those informed, in the light of public opinion, with rational argument and freedom from prejudice and therefore not by the GP on the Clapham omnibus, nor necessarily by the next author in the JME. Meanwhile I shall retire to my own practices.

References and notes

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- (2) Williams A. Quality-adjusted-life-years. *Lancet* 1987; ii: 1372. Williams further discusses the issue of 'Cost-effectiveness analysis: is it ethical?' in the *Journal of medical ethics* 1992; 18: 7-11.
- (3) Cubbon J. The principle of QALY maximisation as the basis for allocating health care resources. *Journal of medical ethics* 1991; 17: 181-184.
- (4) Lewis P A, Charny M. Which of two individuals do you treat when only their ages are different and you can't treat both? *Journal of medical ethics* 1989; 15: 28-32.
- (5) Goodman N. Resource allocation: idealism, realism, pragmatism, openness. *Journal of medical ethics* 1991; 17: 179-180.
- (6) Langford M J. Who should get the kidney machine? *Journal of medical ethics* 1992; 18: 12-17.
- (7) Black D. Paying for health. *Journal of medical ethics* 1991; 17: 117-123.
- (8) Warnock M A. *A question of life: The Warnock report on human fertilisation and embryology*, 1985. The findings of a public enquiry set up to make recommendations on the ethical problems emerging from new technology.

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Unprincipled QALYs: a response to Harris

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I should like to reply briefly to Professor Harris's response to my article on QALY maximisation (1,2).

Harris writes that it is an article of faith among QALY advocates that resources are scarce. That is the wrong way of putting it: the scarcity of resources is an inescapable part of the human condition. Consequently in any distribution of health services, there will be winners and losers; and if the distribution is rational, it will normally be possible to identify, at least by a description, those whose needs will not be completely met.

The word 'Utilitarianism' does not appear once in Harris's response. Yet my article was a fairly straightforward

application of a mainstream version of that ethical standpoint (plus a few factual assumptions) to the problems of health care resource allocation. Arguably Utilitarianism is a product of the Industrial Revolution; but Utilitarian arguments are at least as old as Plato's *Republic* (3). Therefore I cannot believe that the essence of the approach for which I was arguing can be satisfactorily attacked with ephemeral slogans such as 'ageism', 'sexism' and 'Thatcherism'.

References

- (1) Harris J. Unprincipled QALYs: a response to Cubbon. *Journal of medical ethics* 1991; 17: 185-188.
- (2) Cubbon J. The principle of QALY Maximisation as the basis for allocating health care resources. *Journal of medical ethics* 1991; 17: 181-184.
- (3) Plato. *The Republic*. Penguin: Harmondsworth, 1974.

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