Guest editorial

Need - is a consensus possible?

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Medical care is commonly cited as a service to be distributed according to “need”. There are those, (such as Barry and Flew, who interpret “need” instrumentally, that is, that the thing or state asserted to be needed is necessary to achieve some more ultimate purpose. This view is opposed by others, such as Miller and Thomson, on the ground that statements using the word “need” are intrinsic or elliptical, implying an objective that would be trivial to make explicit (the statement “I need open heart surgery” is not much elucidated by adding “if I am to live”). In medicine (and elsewhere too, no doubt) the intrinsic concept is hardly tenable: the great value of the instrumental view is that it confronts practice with the necessity to be explicit about whether it is effective, how effective it is and for whom. Since much practice has in the past been demonstrably ineffective (if not plain harmful) emphasising the role of medicine as a means rather than an end in itself is a non-trivial matter and, on the face of it, the instrumental approach seems to be a useful point of departure.

It may be an illusion to suppose that there might ever be a consensus about the meaning of “need”, even if the context of its use were specific (thus permitting other concepts in other contexts) and even if it were merely provisional (contingent on a manifest improvement for the context in question or a generalisation that embraced this and other contexts). The attempt seems, however, worthwhile.

The context I propose is a planning context in which broad decisions have to be taken about the allocation of resources, for example (British) to the National Health Service (NHS) out of the health vote, or to regions in the NHS, to health authorities in regions, or to trusts and general practitioners by health authorities through commissioning, to decisions about priority groups of beneficiaries, or as between preventive and other types of health care. Common features in all these decisions are that they relate to aggregates of people rather than specific individuals with their own preferences, fears and personal circumstances, all of which normally require attention in individual decisions (preferably joint, for example, by doctor and patient).

I suggest that the concept of “need” in these situations ought to have two elements. The first is empirical: given a goal defined in terms of outcome, there should be empirical evidence (preferably valid and reliable) that the thing or state said to be needed can (with acceptable probability) actually achieve the goal set. The second is ethical: the goal set and the means adopted to realise it ought to be ethically compelling. It is this latter requirement that gives “need” its ethically compelling quality, while the former requirement is essentially a cost-effectiveness condition embodying technological knowledge about the effects on outcomes that procedures may be expected to have and opportunity costs, so that the means chosen to realise the goal maximise the residual availability of resources to meet similar needs of other groups and individuals for similar morally compelling goals.

Thus, one might assert that “health” is needed if people are to “flourish”, that there is indeed evidence to support the proposition that “health” will actually enable the group in question to “flourish” better, and “flourishing” is indeed the ultimate ethical good which transmits its moral persuasiveness to “health”, making that too a good thing (an instrumental good thing). In such a case, ill health indicates a need (for health). This may come close to what some have taken as the intrinsic view. Or, one might argue that health care is needed if people are to have better “health”, that the specific health care proposed is likely to produce the appropriate “health” gain sought, and that the ultimate good of “flourishing” now transmits its moral persuasiveness to health care, which is therefore an instrumental good thing for the achievement of better “health”. In this case, ill health does not necessarily indicate a need for health care, evidence of its cost-effectiveness being required to reach this conclusion. This contrasts with Daniels’ for whom the need for care depends not on the ability of care to return a person’s impairment to the “normal opportunity range” but on the magnitude of the existing shortfall from
that range, which I would interpret as a need for "health", not health care.

I assert that the need for health care is the amount (and type) of health care that is necessary to eliminate a person's capacity to benefit from it in terms of "health" gain. This is not the same as identifying need with capacity to benefit. Embodied in this is the idea that only cost-effective care is relevant (so, for example, a more costly procedure having the same probable outcome for "health" cannot be necessary to achieve the objective and therefore neither is it needed since there is a cheaper alternative whose use will incidentally but importantly leave more resources over to meet other needs). This definition of the need for health care does not imply either that each need should be completely met nor that all individuals' needs should even be partially met. Some unmet need (for example, an additional day in hospital) may add so little additional benefit that other higher marginal needs trump it while other needs may be so minor in their totality that one may not even begin to provide health care in such cases, and for the same reason. (More on categorical absolutes later.)

**Analytical benefits**

This approach has a number of benefits. Some are analytical. One is that we can draw a meaningful distinction between the need for "health" and need for health care (for example, an individual may unambiguously need "health" but not need health care, perhaps because the care that is or might feasibly be available will not affect "health" for the better). Another analytical advantage is that one may substitute both other ultimate objectives (than "flourishing") and proximate means (than health care). One might, for example, think "flourishing" an inadequate ultimate objective for hospices and want to substitute something more appropriate from which would cascade a derived need for hospice care. Or the need for better housing or parenting or social care (rather than health care) might be justified via a "flourishing"→"health" route (as well as others).

Yet another is that the concept can be used explicitly in criteria for distributive justice in health care. For example, is distribution of health and social care a proper ultimate objective of distributive justice, with the resultant "health" distribution being whatever it is, or should a desired distribution of population "health" be the driver that determines the distribution of resources? Practical advantages include the incorporation of the drive for evidence-based professional activity into a clear ethical framework, and the provision of a clear set of principles to inform scoping exercises, research priorities, data collection to support future allocation decisions, and so on.

**Consensus**

My central point here is that the twin structure of the concept is what we may be able to achieve consensus upon, even if we disagree about the value of specific ultimate objectives or the evidence about the cost-effectiveness of alternative means of realising any particular objective. Additional ethical questions arise concerning these details like who ought (morally speaking) to determine ultimate - or even proximate - objectives and whether clinical, managerial or political. My structure does not make presumptions about these answers to any of these questions.

The proposed structure makes no assumptions about the character of the ultimate or proximate objectives (like "flourishing" or "health"). Of course, decisions are required about what we mean by these things and, if it is necessary for them to be measured, what the measure should be, what the required degree of validity is, and so on. But disagreements about these details, important though both the disagreements and the details themselves are, can be managed within the structure and the structure does not dictate specific solutions.

No absolute or categorical sense of need is implicit in the structure proposed. "Need" is not an overriding reason for doing anything. Its persuasiveness depends upon the persuasiveness of the moral objective in question, the cost-effectiveness of the means proposed for achieving it and the resolution of any conflict between needs asserted for one thing on one ground as against the needs asserted for other things on other grounds. It is commonly asserted that "we" need both health care and defence. Both may even have their ultimate moral justification in terms of "flourishing". However, the one set of needs does not obviously trump the others. In both cases it is likely that some needs (one hopes the less pressing ones) are likely to remain unmet because of resource constraints. Need is both relative and graduated since "health" is also relative and graduated - and so is health care. "Health" is variable, for example, in terms of functioning, activities of daily living, experience of pain, mobility, longevity - and it is also at least in part culturally determined. An extreme example of a clinical disease not regarded as "being ill" is pinto (dichromatic spirochotosis), a skin disease so prevalent amongst some South American tribes that the few
single men not afflicted were regarded as patho-
logical to the point of being excluded from
marriage.
Another absolutism is offered by Harris who
argues that life-saving has priority over life-
enhancement, so the smallest possibility of the
shortest extension to the most miserable of lives is
to receive priority over the most sure and massive
improvement in the quality of a life already
expected to be long. This seems a cruel implica-
tion of absolutism: a moral commitment held
irrespective of its consequences and the harm they
might inflict.

Interesting sideline
An interesting sideline arises when one considers
what is being taken for granted, organisationally,
economically or technologically. For some pur-
poses one might want to take existing structures,
budgets and technologies as given (for example, in
deciding where cancer services need to be
located); for others one might want to address
budgets or structure explicitly and ask what a
needs-led “system” requires of these; for others
one might want to engage in horizon scanning in
order to anticipate coming technologies and
better plan their needed diffusion; for yet others
one might want actively to encourage certain lines
of research in order that they might develop tech-
nologies to address needs for “health” that current
technologies are ineffective for and for which
there is therefore currently no need. It thus
becomes possible to talk in the same way about
the need for research and development as for the
need for health care.

Though instrumental in character the structure
does not imply that procedures (like medical care)
or states (like being “healthy”) are always merely
instrumental for more ultimate purposes. While it
is (practically speaking) a good discipline for (say)
general practitioners (GPs) to reflect on the
evidence base for their judgments about how to
meet the needs of patients (collectively or
individually), medical care does not have the sole
purpose of making people’s “health” better than it
otherwise would have been. General practitioners
also provide information, reassurance, other kinds
of advice and opinions for other kinds of purpose
(such as insurance claims). These may promote
“flourishing” (or something else that is highly
morally compelling) but they are hardly medical
care and may not even involve medical judgments.
So, while the health care system’s main job (the
secretary of state asserts) is the promotion of
“health”, there are other functions too, which
may be needed. Whether they are needed or not can be
considered within the structure I propose. More-
over, even procedures and organisational struc-
tures that are primarily intended to be instrumen-
tal means towards some more ultimate moral goal
are commonly required also to show other (moral)
characteristics. For example, cheap access (not the
same, of course, as equal access) to a GP
gatekeeper may be needed (in my sense) if the
twin goals of better “health” and a better distribu-
tion of it are to be realised. But cheap access may
also be morally justified on other, for example
communitarian, grounds. Or a GP may decide
that some types of patient need (in my sense) a
procedure that is known to be generally (cost-)
ineffective relative to placebo but which she may
have rational and evidential grounds for suppos-
ing would actually yield a more substantial
placebo effect for the specific types of people in
question. If such a procedure were thought to be
the more cost-effective treatment plan, then it is
needed. Of course, in such cases (at least if they
were common in a particular practice) the pattern
of care might become an object of scrutiny of
health authorities, who ought likewise to bear in
mind that evidence-based medicine is intended as
an aid to thought rather than a substitute for it.
Moreover we commonly require organisational
processes to meet certain tests, such as openness
or confidentiality (depending on the circum-
cstances), which may also be said to be needed (in
my sense) or which might derive their moral justi-
fication in other ways. Thus, while there are some
issues which are usefully considered in terms of
“need”, others might be better considered in the
realm of rights and entitlements (for example, a
right to be consulted about a medical procedure
before a decision is taken). There is no especial
reason why an instrumental view of need should
not sit within a pluralistic view of medical ethics.

Implications
The following implications (of many) flow more
or less directly from this kind of analysis:

(a) need for health care and ill “health” are not
synonyms;
(b) capacity to benefit from health care is not a
synonym for the need for it;
(c) need is prospective rather than retrospective
(it draws attention to what can be done for people
rather than what has previously happened to them
or what their present state is; past and present are
relevant only inasmuch as they may affect what
can be done or suggest lessons for avoiding future
ill “health”);
(d) it will usually be equitable for some needs to
go unmet (if resources are insufficient to meet all
needs);
(e) it will usually be efficient for some needs to go unmet (if resources are insufficient to meet all needs);
(f) if equity requires that services go only to those who need them, then access to the health care system needs to be cheap rather than equal (in order that needs may be assessed), so cheap access is instrumental too!
(g) although it is instrumental, the usage proposed for “need” is not exclusive of other ethical systems.

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References


News and notes

Journal of Medical Ethics - http://www.jmedethics.com

Visitors to the world wide web can now access the Journal of Medical Ethics either through the BMJ Publishing Group's home page (http://www.bmjpg.com) or directly by using its individual URL (http://www.jmedethics.com). There they will find the following:
- Current contents list for the journal
- Contents lists of previous issues
- Members of the editorial board
- Subscribers' information
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- Details of reprint services.

A hotlink gives access to:
- BMJ Publishing Group home page
- British Medical Association website
- Online books catalogue
- BMJ Publishing Group books.

The web site is at a preliminary stage and there are plans to develop it into a more sophisticated site. Suggestions from visitors about features they would like to see are welcomed. They can be left via the opening page of the BMJ Publishing Group site or, alternatively, via the journal page, through “about this site”.

News and notes

Therapeutic jurisprudence

The First International Conference on Jurisprudence will be held at Winchester, England from July 8-11, 1998.

Some of the key conference themes are: The rights of victims and witnesses in legal proceedings; The “psychological values” which the law should enforce, and Legal review of risk assessment and management.

For further information consult the conference website http://www.soton.ac.uk/~law/bstj.html or Jill Elliott, BS&LN Manager, Law Faculty, University, Southampton, SO17 1BJ, UK. E-mail: jill.elliott@soton.ac.uk. Telephone: +44 0(1)703 592376.