THE ETHICS OF HEALTH CARE RATIONING

AN INTRODUCTION

GREG BOGNAR AND IWAO HIROSE

ROUTLEDGE

The Ethics of Health Care Rationing

Should organ transplants be given to patients who have waited the longest, or need it most urgently, or those whose survival prospects are the best? The rationing of health care is universal and inevitable, taking place in poor and affluent countries, in publicly funded and private health care systems. Someone must budget for as well as dispense health care whilst aging populations severely stretch the availability of resources.

The Ethics of Health Care Rationing is a clear and much-needed introduction to this increasingly important topic, considering and assessing the major ethical problems and dilemmas about the allocation, scarcity and rationing of health care. Beginning with a helpful overview of why rationing is an ethical problem, the authors examine the following key topics:

- What is the value of health? How can it be measured?
- What does it mean that a treatment is "good value for money"?
- What sort of distributive principles – utilitarian, egalitarian or prioritarian – should we rely on when thinking about health care rationing?
- Does rationing health care unfairly discriminate against the elderly and people with disabilities?
- Should patients be held responsible for their health? Why does the debate on responsibility for health lead to issues about socioeconomic status and social inequality?

Throughout the book, examples from the US, UK and other countries are used to illustrate the ethical issues at stake. Additional features such as chapter summaries, annotated further reading and discussion questions make this an ideal starting point for students new to the subject, not only in philosophy but also in closely related fields such as politics, health economics, public health, medicine, nursing and social work.

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To Dan W. Brock

Contents

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Introduction

Rationing health care, we suspect, sounds like a horrible idea. For some, the word *rationing* conjures up images of wartime hardships – long lines waiting at distribution points for basic necessities such as bread, sugar, cooking oil, or gasoline. For others, health care rationing sounds like the government intruding on people's private lives with its bureaucrats lording over life and death, deciding whether Grandma can get her medicines or the life-saving treatment she needs. In some countries, the idea of rationing raises fears about privatizing cherished universal health care systems, destroying social solidarity and reducing people to commodities.

Rationing, in its broadest sense, is the controlled allocation of some scarce resource or good. It implies that limits are placed on its availability. People who need or want the rationed good are restricted to getting it in a certain quantity or size or at a certain time. They are not free to use or consume it in the way they want.

In health care, rationing can apply to treatments, services, pharmaceuticals, medical procedures, and so on. When health care resources are rationed, patients may be restricted to certain treatments. They might be placed on waiting lists. There might be limits on how often they are eligible for diagnostic procedures or screening tests. And, in the worst case, patients may be denied beneficial or even life-saving treatments and interventions. No doubt many people feel that rationing health care is not just a nuisance – it can seriously affect quality of life, and it might even, literally, be a matter of life and death.

When health care is rationed, then somewhere, someone made a decision about the limits of what is provided or how it is provided. For instance, someone decided that hospitals cannot perform a particular kind of surgery. Someone decided a particular type of medicine is not subsidized. Someone organized patients into a waiting list. As we will say, someone made a *priority setting* decision, choosing which beneficial treatments or interventions are more important than others, which have the best value, which are not important at all. All of these decisions interfere with our freedom to decide, together with our doctors, what sort of

intervention, or treatment, or medicine, or medical technology we need or want. All of them interfere with our freedom as patients and health care consumers. They are choices that are imposed on us. The priorities of those who made the decisions may often conflict with our own priorities.

So, if rationing health care is a horrible idea, the *ethics* of rationing health care is even worse. It sounds like an oxymoron. If rationing health care is horrible, how can it be ethical?

Our aim in this book is to show you that health care rationing not only *can* be ethical, but it *must* be. Our case is very simple. We shall argue that the rationing of health care resources is inevitable. It takes place in all health care systems – public or private, rich or poor. It is not only inevitable, it is actually ubiquitous. So you might consider it a necessary evil. But then it is crucial that it is done as ethically as possible to reduce its evil. Hence you should care about the ethics of rationing health care. It is not an oxymoron.

Actually, we will also make a stronger argument. We will argue that rationing in health care is not only inevitable and widespread, but it is also *desirable*. Health care rationing, or setting priorities between alternative resource uses, is far from a necessary evil – it is a good thing. We all benefit when health care resources are allocated in a morally defensible way. This is another reason why you should care about the ethics of rationing health care.

To many people, these claims may sound incredible. They associate health care rationing with poor countries. It is not something, they believe, that takes place – or should take place – in affluent countries. But the truth is, the health care systems of the most developed countries do ration health care one way or another. As a matter of fact, the careful rationing of health care is one of the factors that make a health care system work well. The best health care systems in the world do it.

Other people associate health care rationing with governments. It is, they believe, something that takes place only in single-payer, government-run health care systems. Some people who have this belief probably have private health insurance. So they believe they are not affected by rationing.

The truth is, privately run health care is rationed just as much as publicly run health care. The rationing is done by the companies providing health insurance. They might offer a choice between different plans, but they all involve limits and controls on what they offer. Rationing is not confined to governments only.

When we were planning this book, many people advised us against using the word *rationing*. They worried about its negative, and often political, connotations. Some philosophers have recently stopped using the "R-word" altogether. We believe this is a mistake. It's a perfectly

accurate word for the subject. It should not be yielded to those who attempt to use it to raise public fears for their own political gain. It should be defended. Health care is too important to allow the muddying of the waters by a fear to call things by their names.

Our central claim is that the rationing of health care is an ethical problem. Setting priorities in health care must be based on sound moral principles. This book provides an introduction to this complex topic. While there are excellent books on health care rationing in philosophy, health economics, and health policy, they tend to be written with a specialist audience in mind. We are unaware of any other entry-level book. In fact, our topic has, until recently, received little attention in ethics.

The area of philosophy that is closest to our concerns is bioethics. Traditionally, bioethics has focused on ethical issues that arise in the doctor–patient relationship and in medical research. It has addressed topics such as the permissibility of abortion or physician-assisted suicide, embryonic stem-cell research, respect for patient autonomy, or the protection of research subjects. More recently, as health care has become an important focus of public debate all around the world, some bioethicists have started to address questions that arise at the population level – for instance, questions about increasing international and domestic inequalities in health, the health-related causes and consequences of poverty, the aging of societies, and the allocation of health care resources. This relatively new area of philosophy has become known as *population-level bioethics*. We have learned a lot from people working in this area, and we point the reader to their works at the end of each chapter in the *Further Readings* section.

The problem of health care rationing is complex. For one thing, most examples of rationing in health care are rather mundane, uncontroversial, even boring. They concern setting levels of subsidies for pharmaceuticals, levels of co-payments for health care services, reimbursement policies for medical devices, and similar decisions within complex administrative institutions. They do not make for striking examples. The examples that are usually employed in discussions of rationing are more fascinating, but also more unusual, and hence less representative. They concern expensive cancer drugs that provide a few months of remission at enormous costs, patients on waiting lists for scarce transplantable organs, or priority lists for vaccinations during an influenza pandemic. We ourselves will use such examples in this book. But it is important to keep in mind that most examples of health care rationing are much more pedestrian.

In addition, health care institutions differ from country to country. To keep our discussion concise, we ignore many of these differences. Our aim is to highlight the general ethical questions and moral principles that apply equally to different settings and health care systems. We focus on the general issues that any attempt of priority setting must face. For

instance, we do not have anything to say about whether a health care system should be run publicly or rely on private health insurance, or how taxpayers and patients should share the costs of health care. But the questions we do raise are relevant to various institutional arrangements. Our hope is to furnish readers with a clear understanding of at least the basics of the complex problems surrounding the ethics of health care rationing.

Still, there are many questions and ideas that we have to address in this book. Before we embark on the journey, it is worth having a road map in our hands.

We will begin in the next chapter by defending the two claims that we have already made. We show why health care rationing is widespread and explain why it is also inevitable. The explanation has to do with the unavoidability of scarcity. We present some general ways in which scarcity arises in health care. In later chapters, we will give more specific real-life examples of resource scarcity and the way rationing can address it. Before that, we also give a very brief introduction to moral argument and explain some central ethical concepts and ideas. This will provide the necessary background for later discussions.

If the rationing of health care resources is inevitable, then we must be able to compare different resource allocations as better or worse, acceptable or unacceptable, and so on. Since the goods and resources that are allocated in health care are diverse, we need common criteria for their evaluation. Chapter 2 addresses this issue. Naturally, you might think, a common criterion should be health: one way of allocating resources is better than another if it results in better health for people. But health is not a quantity that can be measured, like weight or height. Its measurement consists in considering its value, through its impact on quality of life. We explain how researchers try to measure the value of health by examining the quality of life judgments that people make about the badness of health states. These judgments can help compare alternative allocations. But measuring the value of health is riddled with problems and puzzles. We present some of these problems and puzzles in connection with two of the most widespread measures of the value of health: quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs).

For readers new to our topic, Chapter 2 is probably going to be the most tedious in this book. We apologize for that. Nevertheless, it introduces concepts and ideas without which the material in subsequent chapters would be much more difficult to understand.

Chapter 3 is about cost-effectiveness analysis. This is the policymaker's main tool for evaluating the costs and benefits of different interventions and health care services. But the use of cost-effectiveness analysis for

setting priorities among different uses of health care resources is controversial – not only among academics and policymakers, but also among the general public. In this chapter, we explain how cost-effectiveness analysis works, address the main ethical problems of its use, and correct some misunderstandings that often appear in discussions. We also present several examples.

Chapter 4 addresses two problems for cost-effectiveness analysis. One of these problems is discrimination against people with disabilities and chronic health conditions. Some people believe that if health care resource allocation is based on a principle that directs you to maximize health benefits, you will often give priority to people without disabilities, and the health care needs of people with disabilities will be neglected. We show that this worry is based on misunderstandings. But the objection does raise some important issues about moral considerations that would be ignored if we focused only on costs and benefits.

The second problem is discrimination by age. Some people believe that age should be a relevant consideration in the allocation of health care resources. In particular, the health needs of younger people should have higher priority than the health needs of the elderly. We try to provide a coherent formulation of this view, but we ultimately leave the question of age discrimination open. People have different moral intuitions about particular cases, and controversies about the role of age and disability in resource allocation have arisen in many practical applications. With aging societies and the ever-growing prevalence of chronic illness, these controversies are going to become more and more acute. We close this chapter by discussing further moral considerations that could be used in conjunction with cost-effectiveness analysis.

Chapter 5 broadens the discussion by connecting the problem of health care rationing to more general debates in ethical theory. This is the chapter in which you encounter striking, imagined and real-life examples of deciding who should live and who should die. Our aim is to show how some of the moral principles used in health care resource allocation lead to familiar, but deeply controversial, problems in ethical theory. These problems concern the aggregation of benefits across different people, the moral justification of taking into account the number of those who benefit, and the use of lotteries in life-and-death cases.

The last full chapter broadens the discussion even further. It begins by focusing on a controversial issue in public health: should individual responsibility for health and healthy lifestyles be taken into account in the provision of health services and treatment decisions? Some influential theories in political philosophy hold that inequalities are not a matter of justice if they are the result of choices for which individuals can be held responsible. It is not unjust if some people end up with disadvantages

through their own choice or fault. Society, as a matter of justice, is not required to come to their aid to reduce their disadvantages.

The theme of individual responsibility is becoming more and more prevalent in public debates. The application of some theories of distributive justice to health care seems to suggest that individual responsibility should have a central role in health care rationing. But very few authors have brought together the philosophical and the practical arguments on this topic. We will connect the two debates. We will also emphasize that the question of responsibility quickly leads to broader issues about the relation between health and behavior, class, race, and socioeconomic status. We give a very brief account of the growing literature on the social determinants of health that examines these issues.

In the Conclusion, we return to a claim we made a few pages back: that the rationing of health care is not only inevitable and widespread, but it is both morally defensible and desirable. It is a good thing from which we all benefit. Of course, this is the case only if rationing choices are based on sound ethical principles and made transparently and accountably. We conclude by defending this idea.

The arguments and ideas in the following chapters are sometimes complex and might require some patience on the part of the reader. We have attempted to present them as clearly as possible. We do not assume any prior knowledge of philosophy, health economics, medicine, or health policy. At times, we use numerical examples. They never rely on anything beyond the most basic math skills. For those who want to explore the topics in greater depth, each chapter ends with a list of further readings and discussion questions.

1 Ethics and health care

1.1 The vaccination programs

Imagine that you and your team of public health experts are contracted by the government of a remote, tiny island state to vaccinate children against a fatal disease. The disease threatens only children, and each child has an equal chance of contracting it. The vaccination has no side effects and provides total immunity against the disease.

Altogether, there are 1,000 children on the island. Eight hundred of them live on the coastal plains and 200 live in remote mountains. It costs only $1 to vaccinate a child who lives near the coast, but $4 to vaccinate a child who lives in the mountains. It costs four times as much to vaccinate the children in the mountains because it is difficult to reach them.

The problem is that you are only given $800 for this work (this is a very poor country). You and your team cannot vaccinate all the children. Because of logistical reasons, you have to choose between two ways of organizing your vaccination campaign. The two programs are:

(A) vaccinating every child living on the coastal plains, but none of the children living in the mountains;
(B) vaccinating half of the children who live on the coastal plains, and half of those who live in the mountains.

Which program would you choose?

If you choose Program A, 800 children will be vaccinated. They will be protected against the disease. If you choose Program B, half of the children on the plains and half of the children in the mountains will be selected randomly. In the end, 500 children will be vaccinated – 400 on the plains and 100 in the mountains.

We often present this example to our students. We ask them to make a choice between these hypothetical programs. We get very consistent results. A majority of the students in any class chooses Program A, but there is always a fairly large minority that chooses Program B. Students

disagree about the right choice. We have never met a class where there was anything approaching consensus in favor of either program.

Next, we ask a follow-up question from those who are in favor of Program A.

Here is the question. Suppose that just as you are about to leave the island with your team, you get a call from the Ministry of Health. They are happy to tell you that the government has given you another $800 for a second round of vaccinations. Even better, they also have vaccinations available against a second disease. This disease is just like the first: it only affects children, it is invariably fatal, all children have the same chance of contracting it, and anyone's chance of contracting it is equal to the chance of contracting the first disease.

At this point, you have a meeting with your team to discuss your options. For logistical reasons, you must choose between the following two programs:

(C) vaccinating all the children who live in the mountains against the first disease;
(D) vaccinating all the children who live on the coastal plains against the second disease.

If you choose Program C, you will vaccinate all the 1,000 children living on the island against the first disease. If you choose Program D, you will vaccinate 800 children against both diseases. In the first case, you will provide 1,000 vaccinations to 1,000 children; in the second case, you will provide 1,600 vaccinations to 800 children.

Would you choose Program C or Program D?

In our experience, an overwhelming majority of the students who favored Program A chooses Program C. We have met very few students who favor A *and* D.

Those who favor Program A in the first question usually give the following explanation for their choice. The vaccination confers a great benefit – immunity against a fatal disease. It is very important to provide this benefit to as many children as possible. Of course, Program A leaves out the children who live in the mountains. But for each child that you could vaccinate in the mountains, you can vaccinate four children on the plains. Choosing Program A is justified by the benefits that would be bestowed on a greater number of children.

Those who favor Program B have a different explanation. They argue that it is wrong to exclude the children living in the mountains. It is not their fault that they live in a remote place. There is something unfair about discriminating against some of the children merely because they are growing up in less accessible places. If not all of the children can be

vaccinated, you should at least give an equal chance to all of those who live on the coastal plains and all of those who live in the mountains. To these students, this seems to be a requirement of fairness.

Remarkably, those who choose A *and* C tend to give a similar explanation for choosing Program C in the second question. For these students, maximizing the benefits of vaccination is the most important consideration in the first question. But the consideration of fairness appears in the second question and becomes more important than benefit maximization – even if very few students might be able to explain what precisely they mean by fairness.

At this point, those who favored Program B – vaccinating half of the children on the plains and half of the children in the mountains – also get a second question. Here is their question. Just as you are preparing to leave the island, you get a call from the Ministry of Health. You are given another $800 for vaccinations. You and your team have to decide between two programs:

(E) vaccinating the remaining half of the children who live on the coastal plains and the remaining half of those who live in the mountains;
(F) vaccinating all the children who live on the coastal plains against the second disease.

If you choose Program E, you will end up vaccinating all the 1,000 children living on the island against the first disease. You will end up giving out 1,000 vaccinations to 1,000 children. If you choose Program F, you will end up vaccinating one half of the children on the plains against both diseases, the other half of the children on the plains against the second disease only, and one half of the children in the mountains only against the first disease. Altogether, you end up providing 1,300 vaccinations (800 + 400 + 100) to 900 children.

Which program would you choose?

In our experience, a large majority of those who favored Program B in the first question favors Program F in the second question – even if there are typically some holdouts favoring B and E. Program F usually gets a comfortable majority. When asked to explain their choices, students often say that although they continue to believe that it is important to avoid the unfairness of choosing Program A in the first question, they acknowledge that the greater benefits of Program F can tilt the balance in the second question. After all, if you implement programs B and F, you will vaccinate nine tenths of the children against at least one disease, and a significant minority against two.

When we present these questions, we emphasize that we are not looking for "right" or "wrong" answers. Rather, what matters is what we can

learn from the answers about our moral beliefs. And the lesson is clear: most people who consider this example believe that it is important to choose the course of action that will bring about the greatest benefits – but they also believe that it is important to allocate resources in a "fair" way. Of course, we need to say a lot more about the requirement of fairness. But one thing is already clear: fairness and benefit maximization can, and often do, conflict. It is important to find the right balance between them. This book is about how we can do that.

1.2 The ubiquity of rationing health care

The story of the vaccination programs is a thought experiment. By asking you to make moral judgments in hypothetical situations, it is designed to shed light on the ethical principles that are relevant to the distribution of benefits in conditions when resources are scarce. Philosophers often use thought experiments to help analyze difficult questions. They often involve an element of science fiction: you are asked to imagine that you are a brain in a vat, or you are teleported to another planet, or you are deceived by an evil demon. But the vaccination story is different. It is not entirely fictional. It is modeled on a real-life ethical dilemma.

In 2003, the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the "3 by 5" program. The aim of the program was to provide antiretroviral therapy to three million people with HIV/AIDS living in developing countries before the end of 2005. Even if successful, the program would have reached only a fraction of those who could have benefited from the therapy. In the end, the target was met only in 2007. At the end of 2011, around 6.65 million eligible patients in developing countries received antiretroviral therapy, up from 400,000 in 2003. But still less than half of eligible patients had access to therapy.

One controversial aspect of rolling out the program was whether delivery should focus on urban or rural populations. In developing countries, there is a shortage of HIV clinics and health facilities. Concentrating delivery in urban areas ensured that more patients could be reached, but it made the program inaccessible to rural populations. Patients living far from cities could not reach the facilities because of long distances, bad roads, and their inability to pay for transport. Some experts argued that the program should focus on those areas where the infrastructure is already in place, in order to reach as many people as quickly as possible. Others argued that rural populations should not be neglected, even if fewer patients can be served as a consequence.

Thus, policymakers faced the same dilemma as our students in the classroom. The choices they made, however, had real consequences. For

some people, they were a matter of life and death. But national guidelines for implementing the program often treated such dilemmas as merely technical questions: matters that require the expertise of medical doctors, economists, and policymakers. The ethical nature of the dilemmas was rarely acknowledged, and the choices were made without consulting the citizens of these countries.

It is understandable that hard ethical choices are sometimes treated as technical questions. The policymakers who were responsible for broadening access to antiretroviral therapy had to set priorities among competing resource uses. They had to engage in the rationing of health care. But the idea of rationing health care makes people uncomfortable. It entails that there are patients who could benefit from care but have to do without it. Many people get upset when they hear or read stories in which someone is denied potentially beneficial (maybe even life-saving) medical care. In many countries, the very idea of rationing health care is taboo. Politicians who talk about it risk their prospects for reelection. So it is not surprising that rationing choices are often hidden behind technical or medical language.

Still, it is not right. It is the responsibility of policymakers to reflect on the values they take into account when they make choices about the use of social resources – both in health care and beyond. It is our right as citizens to demand that social choices that can potentially have a great effect on our lives are made in a transparent and accountable manner. It is also our responsibility to think through the ethical issues faced by our society. We should have the chance to contribute to their discussion and resolution. To do that, we need a basic understanding of medical and economic matters; but what we need most is ethical argument. Medical doctors and economists can help us understand technical matters, and philosophers can help us with the ethical argument.

So, the first point we want to make is that the rationing of health care is an ethical issue. We all have a stake in getting it right. Next, we want to argue that health care rationing is ubiquitous. It affects all of us.

Some readers might think that the rationing of health care has little to do with their society. Where they live, there is a well-functioning health care system. They might think that rationing is something that takes place mainly in resource-poor environments or the least developed countries. True, the "3 by 5" program targeted middle- and low-income countries. But it would be a mistake to conclude from this one example that only these countries should be concerned with rationing. In fact, rationing is universal. It takes place in poor as well as affluent countries, in publicly funded health care systems as well as in private health insurance.

Other readers might associate the rationing of health care with government – in particular, with faceless bureaucrats in drab offices making

life-and-death choices. In the vaccination program, you probably assumed that you were working for the government or perhaps an NGO (non-governmental organization). But you would have faced the very same choices if you were a private contractor with expertise in public health campaigns. The need to set priorities in health care is not limited to government-run health care systems. Private actors, including insurance providers, need to do it just as much.

Neither is it the case that rationing is an exception in affluent countries, rather than the rule. Most people in affluent countries could probably mention organ transplantation as an example of health care rationing. Because there are many more patients than available organs, patients everywhere are placed on waiting lists. Tragically, some of them die before a suitable donor is found. Waiting lists are a form of rationing. It is not difficult to see how they raise ethical issues. Should priority be given to the patients who have waited the longest, or to those who need an organ most urgently, or to those whose survival prospects are the best? Clearly, these are partly ethical, rather than merely medical questions.

Similarly, many readers might recall the worries about pandemic flu. Because of the fear of a worldwide avian or swine flu pandemic, governments are trying to develop and stockpile vaccines. However, if a new type of virus appears, it might take several months before a vaccine can be developed and produced in sufficient quantities. In the meantime, it will be necessary to set priorities among different patient groups. Who should be vaccinated first? Should it be the young or the old? Those who are already sick, or those who are particularly vulnerable? Is it fair to give priority to those who have dependents? Many governments have drawn up contingency plans for a pandemic. In these plans, they have to answer these questions. Clearly, these are partly ethical, rather than merely technical questions.

These examples are familiar. But they are also the most unusual. They concern extreme cases of scarcity and public health emergencies. In such cases, rationing might be unavoidable. But what about our claim that health care rationing is ubiquitous?

In a way, what is rationed in these examples are people. Patients are matched to resources. The examples present choices about who gets medical treatment or who gets it before others. They make good topics for debate, but they are far from ordinary. Most rationing choices are not like this. They do not concern setting priorities among patients. They concern setting priorities among treatments, services, pharmaceuticals, medical procedures, and so on. They concern *what* to provide in the health care system and how to provide it, not to whom to provide it.

Health care rationing is the controlled allocation of scarce health care resources. Occasionally it takes the form of selecting particular patients or

patient groups. But usually it takes the form of setting priorities among interventions. By "intervention," we mean any use of resources in the health care system that aims to address health problems and risks of health problems. By "resource use," we mean any mobilization of human, physical, financial, or other sorts of assets to achieve these aims.

Thus, when the government decides which pharmaceuticals to subsidize from the health care budget, it engages in rationing. When it decides in which city to build a hospital or clinic, it is an example of rationing. When it introduces a cancer-screening program, it is rationing health care. All of these decisions require resources that could be spent elsewhere. Implicitly or indirectly, all such decisions determine who will benefit. Patients of subsidized medicines have to spend less than others. Residents of the city in which the hospital is built have better access to specialist services.

Private health insurance is no different. When an insurance provider decides which treatments to include in its plans, it engages in rationing. When it determines the co-payments, its choice is an example of rationing. When it refuses to provide coverage for people with preexisting conditions, it is, obviously, rationing health care by excluding these people.

Most of us experience the consequences of rationing at some point in our life. When a doctor prescribes a medicine for you that is not subsidized by the health care system or your insurance provider, you might be facing the consequences of a rationing decision that was made by others. When you are told that you need a procedure but it will take many months before you can get it, it might be because of choices made about the use of health care resources. You have to wait because resources are scarce and hence their allocation is controlled. Perhaps the procedures are scheduled on the "first-come, first-served" basis. This in itself is a form of rationing. The procedures could be scheduled on some other basis.

Most of us are unaware that rationing decisions take place all the time because of the enormous complexity of modern health care systems. Rationing is almost never a matter of simple choices between this or that intervention. Rather, it is a matter of trying to achieve different (and often conflicting) objectives, of making trade-offs between different resource uses, of trying to create as much benefit as possible from limited resources. When we are faced with the consequences of rationing decisions, the consequences are often indirect and sometimes unintended. Indeed, it is not easy to find simple real-life examples of health care rationing. But that is because real-life examples are complex, not because they are rare.

It would be a mistake to think that rationing decisions are intended to make your life harder, or to deny you benefits to which you should be entitled. On the contrary, the rationing of health care ought to serve

the purpose of benefiting everyone. But not everyone can be benefited all the time. Your medicine might not be subsidized because it provides little benefits to patients, and it is better to spend the money on medicines that provide more significant benefits. But you are more likely to take notice when you have to pay the full costs, and less likely to take notice when you benefit from not having to pay the full costs. You will not be thinking on these occasions about the benefits of health care rationing. If health care resources are allocated fairly and efficiently, everyone benefits. But people take the benefits for granted.

This is why the ethics of health care rationing is so important. If health care resources are allocated unfairly and inefficiently, many people will fail to receive benefits that they should, and could, get. This is morally wrong. But even when the allocation of health care resources is fair and efficient, there must be limits on what can be provided. Some patients will be disadvantaged by these limits. Thus, the limits must be morally justified. Otherwise, they impose unacceptable burdens on those patients.

Our discussion so far has left one question unaddressed: Why is rationing in health care inevitable? The answer is *scarcity*. Health care resources are scarce. This is why we must set priorities. But this answer just leads to another question: Why are health care resources scarce? Why can't we simply spend more on health care so that there is no need for rationing resources?

1.3 The inevitability of rationing health care

There are many reasons for the scarcity of health care resources. Some of these are technological: in the last few decades, medicine has made enormous advances. It is now possible to cure many previously fatal diseases and to manage long-term chronic conditions. We can now do more than ever before to restore and maintain health. But being able to do more also means spending more. The expansion of health services accounts for most of the increase in health care spending that has taken place over the last 50 years or so. This will continue. Our increasing understanding of genetics, for example, promises to lead to new, and usually more costly therapies. As our armory to fight disease expands, the pressure on health care budgets is going to increase further.

Other reasons are demographic. Life expectancies are increasing almost everywhere. Meanwhile, in many countries fewer children are born. Aging societies spend more on health. Usually, people need health care the most in their very first, and then in their last few years. In developed countries, aging accounts for a substantive share of the increase in health care spending. Since the populations of many developed countries are aging rapidly, we can expect the growth of spending to continue.

There are also economic reasons. It is difficult to design a health care system that works efficiently. As a patient, you usually do not know enough about your condition to decide on the best treatment. The decision needs expert knowledge. Thus, you are not like a consumer looking for something to eat for lunch, who can use her experience and easily available information to make an informed choice. You rely on your doctor to tell you what you need. Moreover, patients often do not directly bear the costs (or all of the costs) of health care services. Since they are less sensitive to costs, they tend to demand more. When it comes to your health, it is better to be sure. An additional diagnostic procedure may just bring you peace of mind, even if, from a medical perspective, it is unlikely to be useful.

At the same time, doctors are often in a difficult situation. They are obligated to give you the best diagnosis and treatment. But they are also expected to act as gatekeepers – making sure that you use only the services that you really need. There can be a tension between their obligations to you as a patient and their role in ensuring that medical resources are used well. It is difficult to find the appropriate balance between these obligations. If doctors, hospitals, or other actors in the health care system are not sensitive to costs, they are more likely to contribute to the misuse and waste of resources. The problem, to put it in the economist's terms, is that incentives are often distorted in the health care system. Controlling costs is difficult.

Overuse of resources can obviously lead to scarcity. But sometimes this can happen in striking ways. In recent years, researchers have raised the alarm that our indiscriminate use of antibiotics might lead to the emergence of resistant strains of bacteria. For instance, there are worries that extensively drug-resistant tuberculosis might lead to an epidemic in the future. If cheap, easily available antibiotics do not work anymore, the health care system has to rely on more costly alternatives. This is harmful for everyone – each dollar that has to be spent on more expensive antibiotic treatments could have been used elsewhere in the health care system. Everyone would benefit if the use of antibiotics was more tightly controlled.

The way health care resources are distributed can itself contribute to scarcity. According to the data available at the time of writing, the United States spent 17.6 percent of its GDP on health care, almost double the average of the OECD countries, a rich-country club. Yet almost 50 million people – over 16 percent of the population – had no health insurance. Worse, the average life expectancy in the US is lower than in many other countries, including some that are much poorer. Americans do not get better health for the extra dollars they spend on health care. This suggests that a lot of their spending is less efficient than it should be.

Our example about the vaccination programs illustrates yet another way that scarcity can arise. Interventions and health care services are seldom sufficiently divisible to ensure equal access. If you are worried about the distribution of income, you can, in principle, redistribute it any way you like (since money can be divided up as finely as you want). But you cannot redistribute health care resources the same way. You cannot build a hospital in every village. Decisions about the location of health care infrastructure and the organization of health care delivery inevitably create inequalities of access, which can itself be a form of scarcity. In the vaccination example and the "3 by 5" program, the costs of reaching some populations increased scarcity.

Hence, scarcity and access are closely related. We can agree that everyone should have access to basic health care services; no one should be excluded from the health care system. But equal access cannot mean access to everything by everyone. Limits must be set, and they inevitably create restrictions on access to particular interventions and services.

Unequal access is problematic for a further reason. People are generally more tolerant of income inequalities than inequalities in health and access to health care services. They believe that inequalities in income and wealth, at least within certain limits, might be beneficial for society: they create incentives or reflect differential effort. But very few people believe that similar considerations apply to health. Health inequalities have no beneficial social effects, and they rarely, if ever, reflect "effort" (an issue to which we will return in Chapter 6). Thus, many people would consider inequalities in health and access to health care much more troubling than other forms of inequality. Even those who do not consider income inequality unfair might be worried about inequalities in health and in the delivery of health care.

For the reasons listed, scarcity is inevitable in health care. Since it is inevitable, rationing is indispensable: societies must try to allocate the available health care resources efficiently and equitably. This is the only way to avoid inefficiency, waste, and unfairness.

Some people want to resist this conclusion. Scarcity in health care, they argue, should not be managed. Instead, it should be eliminated. Since health is important, we should spend more on it. This objection basically says that there is always more money. You just have to find it.

There is an element of truth in this objection. Surely, sometimes the right response to scarcity is to get rid of it. There are still many people in low-income countries who do not get antiretroviral therapy. More should be spent to ensure that they do. Affluent countries could, and arguably should, do much more to help achieve this.

Even so, the objection underestimates the gravity of the problem. Suppose you become a powerful, but benevolent dictator. Since you want to

use your power to help people, you decide to eliminate scarcity in health care. You decide to spend enough to keep up with technological developments and scientific breakthroughs. You spend enough to meet every medical need in a rapidly aging society. You manage to eliminate economic inefficiencies and distorted incentives from the health care system. You introduce policies to provide equal access to everyone. Have you overcome the need for rationing?

For several reasons, you have not. First, even if the most apparent forms of scarcity are eliminated, others remain. Even if every potentially beneficial intervention is available, you will still have to decide which to offer first – you cannot offer everything, everywhere, all the time. You will still have to decide whether to organize a cancer-screening program or a maternal health campaign first. Time is a scarce resource. There is only so far you can go to eliminate scarcity by spending more money.

Second, you will soon realize that in health care, resource use and its costs can easily spiral out of hand. Suppose you introduce more successful cancer treatments. Because better treatments are available, more people are screened. Since more people are screened, more cases are found and treated. No doubt, it is better that fewer people die prematurely because of cancer. But screening and treatment have increased your costs exponentially, creating scarcity elsewhere in the health care system. So you have to increase spending further, which may in turn lead to further scarcity. Paradoxically, better health services can increase scarcity.

Third, eliminating scarcity itself requires rationing choices, since the only way you can get rid of scarcity is by setting priorities. You can only avoid inefficiencies if you spend resources the most efficient way. You can only achieve better health outcomes for the whole population if you take into account the benefits and the costs of interventions. You can only reduce health inequalities if you set the right priorities among the needs of different groups within the population. These are all rationing questions.

At the end of the day, your "war on scarcity" is likely to leave you with a depleted budget. At this point, you are faced with the question: Was it worth it? Health care competes with other social goods. When resources are spent on health, there is less for education, for infrastructure projects, for national defense. Sometimes, resources spent on health would do more good elsewhere. Priorities must be set both within health care and between health and other social objectives.

So, no matter where you turn, you face the need for rationing. Even for a benevolent dictator, this must be very annoying.

Some people might object that since health care saves lives, expenditures on health (or at least on life-extending interventions) should have absolute priority. But there are other ways to save lives. Highway safety regulations are a more effective way to do it. Moreover, few people would

agree, on reflection, that saving lives should always have priority. Later in the book, we will describe some examples of drugs that can extend the lives of people with terminal cancer for a few weeks or months – at enormous expense. All the money spent on these treatments has to come from somewhere. There is nothing morally objectionable in asking whether these treatments are worth their costs. There might be a point at which saving lives is just not worthwhile any more.

Other people reject the need for rationing for another reason. Health, they argue, is fundamentally important to well-being. Because it is so important, you are entitled to it: you have a right to health. If you have a right to something, then you should be provided with it, and you should be provided with it even when the cost–benefit calculation is unfavorable.

But the idea of a right to health is ambiguous at best. At some point in your life, you will inevitably fall ill. You will die some day. Are your rights violated then? Who violates them? It is better to treat the right to health as a right to *health care*. But this is problematic too. Do you have a right to all sorts of health care, no matter how little the benefits? What about the costs? (Do you have to bear the costs yourself? If you have a right to something, should you bear its costs? What if you cannot afford it?) The right to health care had better not be interpreted as the right to any amount or form of health care. At the most, it should be interpreted as a right to *basic* health care: as the right to fundamentally important forms of health care.

Interpreted this way, this proposal just takes us back to the original issue. You have to decide which interventions and services are "basic" or fundamentally important. Surely, those that have the greatest benefits or prevent the greatest loss in health should belong to this group. Interventions and services that bring little benefit should not. But making this distinction requires you to settle questions of priority. It does not liberate you from the need to face the question of rationing – in fact, it requires it. Treating some forms of health care as a matter of rights does not avoid the problem. It just conceals it.

Scarcity is always present in health care systems. Therefore, rationing is inevitable. If you try to eliminate or minimize scarcity, you have to set priorities. That also requires rationing. You cannot escape it. Since rationing is inevitable, it is all the more important to get it right. Since it is a moral issue, "getting it right" requires thinking carefully through the ethical questions that it raises. This is what the following chapters will help you do.

Before we embark on this project, we need to introduce some general ideas about ethics. How can we settle moral questions? How should ethical argument proceed? What are the main ethical concepts and theories that are relevant to the topic of this book? We will now look at these questions before returning to health in Chapter 2.