

## Justice and the allocation of healthcare

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The cohesiveness of a democratic society is founded on a shared feeling that the achievement of health equity is a central consideration for policy makers. However, this ultimate goal over the long term is often too far-sighted for policy makers. Politicians are accountable to their constituents over rather shorter periods of time than would be required to observe the effect of policy on the fair distribution of improvements in health. Society's expectation of justice includes both concerns about the processes by which equity in health is to be achieved, and about the fair distribution of healthcare.<sup>1</sup> In this chapter, although we focus on the distribution of health *services*, we are, of course, mindful that this is only a part of a much broader debate about health and justice in society.

Aristotle stated that justice in the distribution of all material and immaterial goods in society is not based on strict equality, which would result in nonsense or injustice, but on proportional equality.<sup>2</sup> For one person, quantity A of a particular good is the equivalent, for another, of quantity B. This also applies when we come to consider not the allocation of different quantities of the same good, but the allocation of a variety of goods. Translated into the language of modern economic theory this means that the 'marginal utility' of the goods distributed (i.e. the additional benefit one individual gains from using one additional unit of a material or immaterial good) should be equal for all members of society.

The problem is to decide the just criterion for determining the appropriate quantity of that particular good that should go to each individual. Depending on the nature of those goods, and the society, the criteria used to decide the just proportions due to each individual might relate to the individual's work, rank, need, perceived virtue, and so on.

Should this criterion be the same for all goods or should it differ according to the good distributed? If all goods are of the same nature then the same criterion should be used to determine the quantity of goods given to each individual in proportion to work, merit, rank and so on. If they are not of the same nature, then the task is to find a typology of goods that allows us to group them in clusters and to find the appropriate criterion for distributing them in just proportions to each member of society.

The idea that material and immaterial goods belong to different orders was beautifully described by Pascal.<sup>3</sup> Pascal states that tyranny (i.e. the opposite of justice) reigns when one tries to appropriate goods that belong to one 'order' by using means that belong to another. The following are examples of orders (a more spiritual word than 'groups', or 'clusters') of goods, and of the corresponding means to obtain them: love 'corresponds' to beauty; fear to strength, and trust to science. Therefore it is tyranny (unjust) for the strong to demand love, or for the

beautiful person to demand fear. Pascal's analysis, the intuition that for each good there is an appropriate means of obtaining it, was the inspiration for Walzer's analysis and description of the spheres of justice.<sup>4</sup> Our objective here is to examine the application of these insights to the provision of healthcare.

In a just society the allocation of goods follows criteria which depend on the 'sphere' the good belongs to. Firstly, for each sphere (Pascal's 'order') there is an explicit and legitimate criterion for obtaining it. In this sense it is just that one obtains love because of one's beauty, or esteem because of one's intelligence. Secondly, in no sphere should there be a monopoly, i.e. one individual or a group of individuals having all the goods belonging to this sphere. Thirdly, there should be no dominant sphere, i.e. people who own the goods belonging to one sphere would be able to own the goods belonging to all the other spheres. Finally, we should not use the criterion that corresponds to one sphere to obtain goods that belong to another sphere (just as the strong cannot obtain love, or esteem, or trust).

In democratic societies we acknowledge four legitimate criteria for the allocation of material goods: strict equality, need, merit and the market. Undemocratic societies apply other rules.

*Equality* signifies that a good, a service or a right is given to all regardless of their ability to pay, regardless of what they request or what they are deemed to deserve. The same good is given to all without difference or discrimination. The person who benefits from this allocation is not required to pay, the good or service being paid for through some mechanism of social solidarity.

*Need* signifies that goods or services will be provided only after an independent assessment of what is required. It is the external and objective nature of the assessment that distinguishes need from demand. This point is particularly important in the field of healthcare where demand, which perhaps stems from our desire for immortality, tends to be infinite. The provision of healthcare in response to need is paid for through social solidarity.

*Merit* signifies that a person can obtain a gratification (for example, a position in public office with an income attached) as a consequence of that individual's achievements recognised by votes, or success in examinations or recognition of past endeavours. The worthiness of the beneficiary must be proven by objective measures and not the whim of princes.

For the sake of simplicity, we consider that any good for which a person is required to pay, either directly or by purchasing insurance, is allocated in accordance with the mechanisms of the fourth criterion, the *Market*. The assumption, implicitly made by society when healthcare is allocated in this way, is that individuals should be free and empowered to make choices about the goods (healthcare among them) that they wish to purchase. In this, society does not concern itself with the justice of final outcomes, only that the processes are considered just. If the market is so organised that the same rules are followed by everyone without cheating, there is no injustice even if, eventually, some persons end up having more than others. Any interference from the state (for example, to ensure some provision of baseline care through taxes or social charges) is held to curtail unjustly individuals' freedom by imposing its own hierarchy of values.

The weight given to these different ideas of justice varies over time in any given country, and, at any one time, varies between different countries. We focus here

on the legitimacy (for the allocation of material goods in general, and of healthcare in particular) of the allocation principles or criteria chosen in today's democracies.

Goods in relation to citizenship and politics, such as voting rights that are now allocated on the basis of equality (one person gets one vote), were in earlier times allocated on the basis of net worth. Similarly, care for emergencies and catastrophic illnesses, now provided free of charge in most EU countries on the basis of need, used to require payment – at least from those who could afford it. The allocation of education according to need, and not according to the market (the ability to pay for a private tutor), was proposed by Condorcet during the French Revolution.<sup>5</sup> It took almost 100 years to be fully implemented. Public positions in the civil service or senior positions in the military are now obtained by merit, externally judged on the basis of examinations or performance. In the past such posts were purchased from the king or his representatives.

The point here is that there is no eternally and universally recognised acceptable and proper allocation principle for a given good, only one that is felt just in a given country at a given time, one that reflects how the society translates its ideas about justice.

In a just and democratic society the allocation criteria chosen for a given good or service must be explicit and considered legitimate by all. When such is not the case, for example when public offices are found to be bought or preferentially distributed, or when social housing is traded and not allocated on the basis of need, society demands some form of redress. It follows that, when an allocation principle is considered legitimate for a given good, it should apply to all in society, and should not be changed without due consultation with the stakeholders. For example, decisions about removing medicines from formularies mean that a medicine whose cost was previously reimbursed (i.e. allocated on the basis of need) must now be purchased by patients (i.e. allocated by market mechanisms). While this is indeed the current practice in many countries, its acceptability by the public and the pharmaceutical industry requires explanation and justification from governments.

Lastly, there is an ethical requirement that, whichever criterion is chosen, the distribution of goods must be just and efficient in economic terms. Injustice is experienced at the level of the individual (even by libertarians) when poor sick persons cannot be treated. It is also experienced at the societal level when scarce health resources are wasted in responding to futile demands, and so are foregone for other uses.

The application of these allocation principles to the healthcare sector is not straightforward. Each element has to be considered separately. Because of the current pressure to control health expenditures, we are obliged to consider what inefficiencies may result from the choice of one or another principle. And above all, we need to think about how democratic societies apply the concept of justice to the provision of healthcare.

Medicines, doctor's visits, hospital care, preventive care, dental and eye care are allocated by different principles in different countries. In most EU countries, the dominant principle is allocation on the basis of need. There is however a difference between the so-called Bismarck and Beveridge models. The former was initially liberal, and then evolved into one based on strong social solidarity, while the latter was founded on utilitarian solidarity. These models contrast with that in the USA where the dominant allocation principle is the market.

We have argued that allocation principles or criteria must be explicit, legitimate and also efficient. However, the requirement for both legitimacy *and* efficiency is often difficult to satisfy because of the potential conflicts between them. From the end of the nineteenth century, with Bismarck's reforms in Germany, and then in the mid-twentieth century, with the spread of social health insurance systems and national health services throughout EU countries, most curative healthcare has been allocated according to need. However, a major inefficiency in allocating services in accordance with 'need' is that need is often misunderstood as 'demand'. Since demand for healthcare is only limited by our desire for immortality, it may be thought of as limitless. Any threat to our health triggers this desire, and generates a legitimate demand of healthcare. As a country develops and increases its level of wellbeing, demand for *health* increases, and this is often mistaken for a demand for healthcare. Therefore an allocation of healthcare based on the criterion need ('need' which might actually be 'demand') may use up all of society's resources, to the detriment of the provision of other legitimate social goods. It may also create a moral hazard on the part of patients, who then have no incentive to manage their health responsibly, because they assume that even though they do not participate in preventive care – in respect, for example, of cigarette smoking, alcohol abuse, fast driving – curative or reparative care will be provided. Allocation of healthcare based solely on the criterion of 'need as demand' deprives individuals of responsibility for their own health, resulting in negative effects on both individual and on collective health.

In order to limit the inefficiency of an allocation based on this interpretation of need, the assessment of need is made by a physician or other healthcare professional. This external assessment is intended to differentiate need and demand. In countries where professionals are paid on a fee for service basis, however, this assessment by a professional who stands financially to benefit from confirming 'clinical need' creates an imperfect agency situation. While needs assessment can be carried out by government institutions who do not benefit from that agency, these relate only to classes of need. When it comes to the care of individual patients, a health professional is inevitably involved.<sup>6</sup> The opposite risk also exists and is known as the 'gag rule': here, the assessment of need is made under the control of a payer who stands to benefit from a limitation of the care provided.<sup>7</sup>

'Imperfect agency' is not only the source of inefficiency; it also creates inflationary pressure. Although an allocation based on need may be considered legitimate, and result in positive health outcomes for some, it can also create injustice because resources wasted are lost to others, and inefficiency because those who waste the resources do not achieve good health. This leads us to examine how other criteria can perform in allocating healthcare resources justly and efficiently.

Preventive care is mostly allocated on the basis of equality. In the case of immunisation, the justification is the equal utility for all individuals, and the benefit created for society as a whole, by one of its members not infecting others. In the case of screening, the justification of equal access is more difficult to argue, particularly since identifying particular at-risk groups permits efficient, but selective, targeting. It therefore seems more efficient to restrict screening to such at-risk groups, and to use the resource saved (by screening fewer people) to purchase other desirable health goods. However, although efficient, this

approach would meet with opposition from the public on the grounds of justice. There is evidence that populations prefer screening to be allocated equally, even at the price of decreased efficiency.<sup>7,8</sup> In this they would appear to be supported by Aristotelian proportionality that suggests that it must be just to give each individual the same screening test if there is no evidence that some would benefit more than others. And individuals may perceive no evident sign that the utility for some individuals will in fact be greater than for others.<sup>9</sup> For policy makers, however, there is epidemiological evidence that high-risk groups will benefit more, and should therefore receive more.

Merit is seldom used as a criterion in EU countries. Its application to the provision of healthcare would result in goods and services being preferentially allocated to the 'deserving', i.e. to persons who have made some kind of effort or commitment to preserve their health. The negative application of this principle to healthcare would mean that 'reckless behaviour' – such as smoking – would be penalised. Treatments of conditions occurring as a consequence of smoking would not be financed through national solidarity.

Examples of experiments in rewarding virtuous behaviour include full coverage of dental care for patients who attend preventive care clinics in the Netherlands,<sup>10</sup> and better reimbursement for patients who go through the new gatekeeping system recently set up in France (Reform law of the Social Security voted on 13 August 2004). While allocation by merit might be deemed just, and is efficient if it encourages patients to adopt virtuous behaviours and so reduce moral hazard, it can be argued that it is unjust because it favours those in society who have easier access to education, information and so have greater capacity to alter their risk-related behaviour.<sup>11</sup>

Allocation of healthcare through market mechanisms is consistent with the liberal theory of justice. Here healthcare is not considered different from any other sort of good, and can be left to be bought and sold in a competitive marketplace. It is a matter for each individual to order his preferences and devote the resources required to achieve his or her target health status. The amount of resources will depend on where the individual places health relative to other goods, and the price she or he is willing to pay for it.

However, the limitations of this approach were identified as early as the Middle Ages, and resulted in the creation, among craftsmen, of the mutual assistance associations.<sup>12</sup> Later, in the eighteenth, and more actively in the nineteenth, centuries, the state stepped in. While perhaps the first limitation to be identified in the market approach was the injury done to society's sense of justice towards its poorer and more fragile members, latter-day economists too have argued against the market as a sole means of allocating healthcare.

Allocation by the market alone, either directly or via competing insurers, is neither just nor efficient. Arrow points out that market inefficiencies result from the asymmetry of information between professionals, patients and payers.<sup>13</sup> Since patients know more about their own health than do the payers (in this case the private insurance companies) they may tell lies about their actual health risks in order to obtain lower premiums. To cut their potential losses, insurers tend to select patients at lower risk, and to charge premiums for those who are at higher risk, like the elderly. Thus, again, the sicker and more fragile members of society are excluded from coverage.<sup>14</sup>

Empirical evidence from the USA suggests that market mechanisms cannot deal

efficiently with the asymmetry between the physician who decides on the provision of services, and the party who is to pay for it – be it the patient or the third party payer.<sup>15</sup> Libertarians argue on moral and political grounds that an imperfect market is better than the state's limitations on the individual's freedom to establish her or his own hierarchy of preferences. The counterargument is that persons with severe chronic (and costly) diseases do not have the freedom to prefer other goods than healthcare if they want to survive.

From this brief review of the filters of 'justice' and 'efficiency' in determining the provision of healthcare in the population, it would appear that no single criterion can fulfil all our expectations. All healthcare systems counterbalance the negative effect of their dominant allocation criterion, by the partial introduction of others. In systems where the dominant criterion is need, co-payment mechanisms (the market criterion) may exist, or patients may qualify for higher reimbursements if they use preventive services (the merit criterion). And where the market predominates, public funding is made available for the poor, the elderly, or patients suffering from severe chronic illnesses, as in Medicaid and Medicare in the USA (the need criterion).

Our conclusion is twofold: healthcare should probably be allocated by a composite of all four criteria and the respective part to be played by each of them is a matter of political choice. Societies, however, may then require from policy makers that the choice of criterion to allocate particular types of care be transparent and legitimate, and that they then build a hierarchy of priorities in order to establish and demonstrate health equity.

Policy makers must pose the following questions for public debate. Does healthcare belong to a sphere apart from other goods, one for which the dominant allocation criterion is need and not the market? If the answer to this question is yes, there remains the problem of how to compensate for any unjust and inefficient outcomes of this criterion. Other allocation criteria can be introduced for goods and services that would *de facto* be withdrawn from the sphere of healthcare: for example, cosmetic surgery, spa therapy, treatment for 'heavy legs' or the common cold could, by political decision, be transferred to the sphere of goods bought and sold on the market. The trade-off is that, on the one hand, no poor person would be denied treatment, and, on the other hand, that there would be ways to limit the opportunity cost resulting from resources wasted on futile care. Establishing the societal preferences for health through public debate means more than the political expediency of accommodating society's whims and desires. It means giving all the members of society the 'fair innings' they deserve, and respecting their human dignity.<sup>1</sup>

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