Rationing Yes, Politics No. For a Right-based Approach in Rationing Medical Goods*

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1
Basic Assumptions and Goals of the Discussion

I presuppose, firstly, that medical resources are limited and that not every need for medical treatment can be satisfied. Secondly, I presuppose that we do not want to give up a publicly funded health system altogether. However, I will not discuss the reasons in favour of a publicly funded health system here. I simply want to say that a preference for such a health system does not in my opinion exclude the possibility of an additional provision by private insurances. Neither will I make any assumptions with regard to the size of the budget for a publicly funded health system but I think that it will include at a minimum level what can be called a "basic coverage".

If these two presuppositions hold true we then have to answer the question of allocation: according to which criteria should the limited medical resources which are supplied by the state be distributed among those requiring treatment? There seem to be two principal options in answering this question: *equality* or *maximisation*. Their implications with regard to the distribution of vital goods can be illustrated by an example. Imagine that a limited number of life-boats has to be allocated on a ship. According to the principle of equality the boats should be distributed in a way that gives every passenger an *equal chance of survival*. If the aim is maximisation the distribution of boats should try instead to *maximise the survival rate* of the passengers. The distribution of the boats on the various decks can differ significantly in both cases.

If we prefer an allocation of – publicly funded – medical goods according to a principle of equality this would mean in analogy to the distribution of life-boats that everyone should have a right to the same quality of medical treatment, that every ill person has an equal chance to get his illness cured or alleviated. The alternative would be an allocation of these scarce medical goods according to a principle of maximisation – similar to the maximisation of the survival rate of passengers on a ship. This principle can be applied on the macro level of political decisions as well as on the meso and micro level of decisions by hospitals or doctors. It would imply, for example, that on the level of macro-allocation hospitals are only built in areas with a high density of population or on a level of micro-allocation that doctors make a deliberate selection among possible recipients of medical treatment and save medical resources for those who have the best prospects. In this case not

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everyone would have a right to be given the same medical attendance but rather medical treatment would be distributed according to some discriminating criteria. At the margin each unit of money spent on health care would have to yield the same return in terms of cured individuals or lives saved (presumably adjusted by some quality index or other).

Prima facie there seem to be good arguments in favour of rationing restricted medical goods by a rule of maximisation. This strategy in general provides the opportunity to exploit limited resources optimally by using them deliberately in spheres where they have the highest degree of effectiveness. Given that suitable criteria are available – for example maximising life expectancy or "quality-adjusted life years" ("qalys") – the efficiency of a health system will be enhanced significantly if its resources are distributed accordingly. And would such an improvement of efficiency not be in the interest of all concerned? Would it not be the case that a health system that maximises life expectancy or qalys on a general level would also maximise the life expectancy or qalys of every individual? And should not everyone therefore prefer such a health system to a system which distributes its resources without any maximising choices?

In the following I will contradict these seemingly suggestive arguments by putting forward some considerations *against* maximisation and *pro* equality. Or to put it in a slightly different way: I will reason against a consequentialist approach in rationing medical goods and will argue instead for a right-based approach. It should be remembered though that my considerations refer only to a publicly funded health system. They cannot be simply transferred to questions which are connected with private health insurances (cf. Breyer and Kliemt 1994; Kliemt 1995; 1996). And I should say from the outset that my arguments are not applicable either to emergency situations where the problem of "triage" occurs (cf. on this W. Lübbe in this volume). My arguments are directed solely to the question how we should design institutions which have to cope with the distribution of limited medical goods in normal everyday practice.

I will discuss the problem of the allocation of scarce medical resources by way of a digression. I will first take a look at the way in which we regulate the distribution of *other* elementary goods. It may seem that here I can find quick and strong support for my assertion concerning the superiority of a right-based approach also in the case of medical care. It appears to be evident that we in general prefer a framework of rights and equality when distributing vital goods instead of a consequentialist principle of efficiency and maximisation.

2 Taking Maximisation Seriously

If we look at the usual justification of the predominance of right-based theories we find that in the context of *civil rights* it is often argued that maximisation and efficiency as utilitarian principles are collectivistic and show disregard for individual interests. If we apply these principles, it is said, public welfare will override individual welfare. A central embarrassment for such consequentialist or goal-based theories is, as for example John L. Mackie puts it, "that they not merely allow

but positively require, in certain circumstances, that the well-being of one individual should be sacrificed ... for the well-being of others." (Mackie 1978, p 352).

Rights, on the other hand, are seen as protecting the interests of the individual against collective welfare. An order of rights therefore "is *not* saddled with the embarrassing presumption that one person's well-being can be simply replaced by that of another" (Mackie 1978, p 359). Or to put it in the well-known words of another prominent advocate of rights, Ronald Dworkin, rights are *trumps* in the hand of the individual against the claims of the community (Dworkin 1978).

Because civil rights are supposed to be clearly recognizable as safeguarding the individual, this line of reasoning ends with the conclusion that from an individualistic point of view an order of rights is by far preferable to an order of utilitarian maximisation. It would appear to be obvious that a right-based system protects individual interests far better than any other institution.

Closer inspection reveals, however, that this line of argument is, unfortunately, too simple and is missing an important dimension. In fact, even from a strictly individualistic point of view there are good prima facie reasons for adopting a utilitarian principle of maximisation – especially when we are dealing with goods of high value such as are related to civil rights. The alternative between efficiency-based institutions and right-based institutions is not a simple alternative between giving priority to individual interests or giving priority to collective interests. Even under the premise of an individualistic position the superiority of a right-based allocation of goods is not at all evident.

The frequent self-confident appeal to ration medical goods according to a principle of maximisation is thus an indicator of a problem which in my opinion seems to be underestimated in the context of the general discussion on civil rights. Obviously not all advocates of medical rationing by maximisation are anti-liberal "collectivists". On the contrary they assume that such a health system would be in the interest of all of us individually. It follows that we have to take maximisation more seriously – especially if we want to present sound arguments *against* it!

But *why* are there good prima facie reasons for a principle of utilitarian maximisation from an individualistic point of view? These reasons become clear when we place ourselves in an *ex-ante-situation* where we have to choose between different rules for the future distribution of vital goods. If we weigh up our interests in such an ex-ante-situation, it seems to be in the best interest of *all of us* to choose a rule of maximisation instead of a right-based order. The fundamental reason for this is that ex-ante the chance of becoming the beneficiary of a rule of maximisation is greater than of becoming its victim. And this also applies in respect to those basic goods which are candidates for the protection by civil rights.

According to a rule of maximisation the distribution of basic goods such as personal freedom, freedom of speech, health, physical integrity or protection against arbitrary punishment would only then deviate from equality as it is incorporated in an order of civil rights if this enhanced the overall welfare. But this means that *ex-ante* everyone would benefit from such a maximising device because all persons concerned would improve their individual chances with regard to their future personal share of this welfare. Hence it appears to be an obvious and perfectly rational choice for everyone to favour a principle of maximisation and not an order of rights.

This decision does, of course, imply an acceptance of a restriction of civil liberties in situations in which the overall benefit of such measures would surpass their disadvantages. This might be any of the following cases. The execution of a man for a crime he did not commit if several other lives were saved by the deterrent effect. The imprisonment of innocent members of the family of a dangerous criminal if this prevented him from committing serious crimes. The torture of a suspect in order to extract information on the location of a hidden bomb. The expropriation of a landowner if this improved the situation of a great number of other people. The restriction of the freedom of speech whenever the danger of civil riots exists. And last but not least, the use of someone as an organ bank if this could save the lives of several other people (cf. Harris 1980). To me it seems indisputable that there are, in fact, situations in which such intrusions in the elementary interests of certain individuals would indeed be the welfare-maximising choice.

As is well-known it is crucial to Rawls' theory that such ex-ante decisions behind a veil of ignorance would, in contrary, *not* be in favour of utilitarian and consequentialist principles but in favour of a regime of rights. As I see it, he puts forward mainly two arguments to refute considerations like the above. His first argument claims that someone who is risk-averse would prefer a future situation in which his basic interests are secured by rights in all events against being sacrificed for the interests of others (Rawls 1971, ch. 3, § 28). But this argument is not sound. Rawls does not take into account the important fact that an individual can rationally expect to advance exactly these basic interests by a maximising rule: if, for example, one person is sacrificed so that three others can survive (by the transplantation of his organs or by his punishment as an innocent man), then one would increase one's chances of survival ex-ante if one opted for a rule of maximisation and *not* for an unconditional right to live.

The same holds true for other goods which are protected by civil rights. There are always situations imaginable in which I can benefit from the violation of the rights of others to promote for myself exactly the kind of interests which are the subject of these rights. One cannot, as Rawls does, only take cases into account in which rights may be violated in favour of aggregated inferior benefits.

Rawls' second argument hints at the problems which would probably emerge if we tried to execute a principle of maximisation in practice (Rawls 1971, ch. 3, § 29). Rawls is right in claiming that we should only opt for principles which can be realised without making excessive demands on people and thereby endangering the stability of society. We should therefore only consent to decisions in ex-ante situations which everyone of us can also keep ex-post. This is an important argument and I will come back to it presently. Unfortunately Rawls' own rejection of a rule of maximisation on the grounds of this adequate claim is hardly acceptable. Rawls argues that under unfavourable conditions this rule would demand "unbearable" sacrifices from some people in favour of the well-being of others. If this ex-post result comes about we cannot expect the "losers" to observe an ex-ante agreement any longer. Rawls goes on by saying that this danger could be avoided if a system of rights was established because then nobody would run the risk of a violation of his own basic interests for the benefit of others.

But this is only half the truth. The argument has to be elaborated on further. The situations under a rule of maximisation and under a right-based system are more

symmetrical than Rawls suggests. It is not correct to state that in the first case some people who are the "losers" have to sacrifice basic interests for the sake of the "winners", whereas in the second case no one will run the risk of becoming a loser. If, for example, under a rule of maximisation one person had to give his life as an organ-donor for the life of three other persons, his life would indeed be spared under a rule of rights – but it should not be overlooked that the price for *his* right is to be paid by the *other* three persons who now have to give their lives for the life of the potential donor! So likewise, in a right-based system there are of necessity "winners" and "losers". And at first glance it is not at all evident that the three victims in our example have more reason to accept their fate than the organ-donor who is compelled to give his organs in the first place.

The protection of rights *always* has the price of the potential gains which could be earned by their violation. It is not true that these costs in most cases are insignificant for those who have to bear them (this is perfectly clear in the "trolley-case": cf. Rakowski 1993; Thomson 1985). In order to make sense of Rawls' assumption that there is a fundamental problem connected with the practical implementation of a rule of maximisation which would not emerge in the case of a right-based system we have to take a closer look at the problem.

To sum up we can say that up to now we have heard no convincing argument why – from an ex-ante point of view – a right-based system of equal distribution would be preferable to a rule of maximisation as a device for a discriminating distribution of vital goods. And this result does not presuppose any bias towards some sort of "collectivistic" reasoning where individual interests are principally subordinate to the common welfare. The "embarrassment" for consequentialist theories i.e. that they could require the sacrifice of individual well-being to the interests of the majority poses no threat to individuals if it is duly recognised that the beneficiaries of such sacrifices are also individuals and their interests. It seems to be that we are therefore forced to acknowledge the fact that rights do not *per se* guarantee the best possible outcome for each individual.

3
Why Rights?

Nevertheless we have to admit that it is very unlikely that anybody would derive strong motives from these facts to abolish our right-based institutions in the area of civil liberties. Because of this we should be cautious in the case of the distribution of medical goods, too. The fact that there seem to be good ex-ante reasons for allocating limited medical goods according to a maximising rule should perhaps not be overrated. If there are sufficient similarities with the case of civil rights and the refusal of a rule of maximisation turns out to be well-founded here we maybe have good reasons to establish a right-based regime as well in the field of health care.

To prove this we now have to turn to the question *why* we do not apparently consider our ex-ante interests important enough to alter our preference for civil rights and replace them by some kind of efficiency-based institutions. My thesis is that: *if* we are in an ex-ante situation and *if* a rule of maximisation would improve

our expectations in contrast to a rule of rights, we would only decide in favour of this option on condition that it could be guaranteed that

1. a rule of maximisation would be defined and applied in a *neutral* and *impartial* way, and that
2. we could trust in a *mechanism of commitment* which would bind all participants to a rule of maximisation ex-post as well.

I think that as rational actors we are not against maximising per se. But I think we are right to opt against maximisation in many cases because we cannot rationally expect a neutral and impartial institutionalisation and execution of a rule of maximisation and also because there is no mechanism of commitment efficient enough to prevent people from breaking their contracts if their vital interests are at stake. Both doubts are directly connected with the fact that maximisation only is feasible as a *political enterprise* in the fields which are of interest here. Its aims can only be realised by *collective decisions* on a bundle of questions. If, for example, I have the right to live, questions concerning my life and death are not subject to collective decisions. In the case of unrestricted maximisation, conditions under which I am allowed to live and under which I am forced to die *have to be* legally subject to collective decisions.

Seen from this point of view we can now recognise a fundamental difference between a system of maximisation and a system of rights which has not yet been taken into account: Rights are instruments to *limit* the domain of politics in principle and to *reduce* the legal range of collective decisions. The establishment of a rule of maximisation is on the contrary inevitably connected with *political empowerment*. Rights embody a claim to political *omission* and *limitation* whereas rules of maximisation embody a claim to political *activity* and therefore to an *enlargement* of political power.

But *why* should we hesitate to impose upon politics the duty of maximisation in the sphere which is now protected by civil rights? Why should we doubt that politics would apply a rule of maximisation in a way that suits the ex-ante interests of the citizens and expect instead that politics will necessarily or very probably come into conflict with the demand for impartiality and commitment to former decisions?

To answer these questions we do *not* need to presuppose a worst-case scenario. It would not be difficult to give reasons against entrusting a rule of maximisation to an autocratic regime. But the decisive point can be made already in the case of democratic politics under the rule of law. We have to realise that there are at least three kinds of crucial decisions relevant in the course of establishing and practising a system of maximisation. We can call them "decisions on operationalisation", "decisions on implementation" and "decisions on application". Decisions on operationalisation are necessary to transform the principle of maximisation into a manageable rule as a guideline for practice. Decisions on implementation are necessary to establish institutions and rules of procedure for the everyday application of a rule of maximisation. And decisions on application are necessary to determine for concrete cases the consequences of a rule of maximisation.

The problem with this kind of decisions is that their very nature makes them susceptible to arbitrary influences. To operationalise a rule of maximisation we are

not in possession of objective criteria which would guarantee an optimal result for a distribution of goods, burdens, and services. There are no intersubjectively valid standards available to judge the neutrality of such criteria. A large number of alternatives also exist for an institutional and procedural implementation of a rule of maximisation. It is not evident which of them serves the aim of predictability and neutrality in the application of a rule of maximisation best. And last but not least an application of rules which should produce efficient results is in particular tempting for "teleological" reasoning by which a clever interpreter of a rule can easily override its literal meaning by referring to its true "aim".

Therefore, there is ample room for *discretion* in the case of decisions on operationalisation as well as in the case of decisions on implementation and application. And it is a priori *improbable* that in a democracy the neutrality and impartiality of these decisions can be guaranteed.

There are two main reasons for this sceptical assessment:

The first reason is that common ex-ante interests in establishing a rule of maximisation depend on the fact that the participants do not yet know whether they will belong to the winners or losers of this rule. However, that does not prevent them from also having a vital ex-ante interest *not* to belong to the losers in the future but to the winners. *And* they have – at least to some extent – ex-ante knowledge how to operationalise, implement and apply a rule of maximisation so that *they* will not belong to the losers but to the winners – for example in regard to exclusion clauses which restrict the applicability of a general rule. It follows that everyone has ex-ante a strong incentive to form a majority coalition to influence democratic decisions of operationalisation and implementation such as to privilege members of his own group and to *exclude* them from the group of potential losers of a rule of maximisation.

The second reason is that the interests of the participants will *change* ex-post. Common ex-ante interests with regard to a rule of maximisation depend on common risks. In the course of time risks will change, probabilities become calculable, some risks will become reality, others not. The participants will increasingly gain knowledge whether they will join the losers or the winners of a rule of maximisation. Accordingly their evaluation of such a rule will change. So generally there will also be strong incentives ex-post for everyone to form a majority coalition to influence the operationalisation, implementation and application of a rule of maximisation in their own particular interests. These incentives will work against any commitment in favour of an ex-ante agreement.

The room for discretion inevitably allowed by any rule of maximisation and the veil of the rhetorics of common welfare will allow for far-reaching adjustments to a rule of maximisation in the course of its establishment and execution. A path of development will start which will transform the original rule of maximisation to a pure rule of redistribution in the interest of the ruling majorities. In the cases where basic goods are involved, the dynamics will accelerate because of the danger of irreversible damages (cf. on the process of politicisation in particular de Jasay 1991).

These prospects will produce a preference for right-based institutions if the losses one has to fear as a member of a minority outweigh the benefits one can hope for as a member of a majority. This is likely to happen because a majority will have

no reason to give up any small advantage even at the expense of a large disadvantage of the minority. Under this condition a constitutional system of rights which *as a matter of principle* forbids maximisation resp. redistribution by sub-constitutional collective decisions makes everyone better off. This would be true ex-ante and could also be true for most of the people ex-post – given a democracy in which majorities will cycle with certain probabilities (cf. Buchanan/Congleton 1998).

The scales would tip even more to an order of rights if one takes into account the cost of investments in the process of political decision-making which have to be made to preserve one's chances in the political fight for redistribution. Generally political power would gain much more weight and the incentives to participate in the struggle for influential political positions would increase considerably (cf. Buchanan/Congleton 1998). If one argues in favour of the plausibility of a rule of maximisation on the grounds of ex-ante interests one should not forget ex-post interests which lead to the instability and politicisation of such a rule.

If these considerations are well-grounded the idea of rights is not to realize the best possible world. The idea is to give up the aim to strive for the best possible world *by political decisions*. To opt for right-based institutions would amount to renouncing the potential gains which can be realized by a rule of maximisation.

4
Right-based Rationing

What are the consequences of all this for the problem of rationing limited medical resources which are supplied by public funding?

First of all: private goods of fundamental importance are at stake in this case, too. This means that the incentives to become a winner and not a loser will be at least as urgent as in the case of the vital goods which are protected by civil rights. There is an important difference, however: the goods which are at stake in the context of health care cannot be guaranteed by the state by *omitting* certain acts but only by *active performance*. Therefore if one wants to establish rights in this area those rights would be *claim rights* and not the *negative rights* of the classical liberal constitution.

But in one essential aspect – which is of special importance here – there is a decisive similarity between claim rights and negative rights. Claim rights as well as negative rights *limit* the range of collective decision effectively. If one has a claim right to a certain good then it is not the object of collective decision whether one should receive the good or not.

Thus we face the same fundamental alternative as in the case of civil liberties: we can either organise the allocation of scarce medical goods by right-based institutions to ensure equality of distribution or by efficiency-based institutions which would distribute medical goods by some rule of maximisation. In the case of right-based allocation everyone would have a right to the same quality of medical treatment; in the case of an efficiency-based allocation the aim would be to maximise the probability of success, the rate of survival or "qalys".

We can now argue by analogy to the case of civil rights. Ex-ante there seem to be convincing reasons for everyone to opt for an efficiency-based institution. For

everyone the chances of good health, survival or qalys would be maximised. But as in the case of other basic goods a choice of a rule of maximisation would only be imperative if one could rely on the impartial and neutral establishment and execution of such a rule – and if we have good reason for mistrust in other cases we should also be suspicious in the present one.

In the case of maximising medical goods nobody wants to become a loser either and so will have incentives to invest in political decision-making to prevent a bad lot. Everybody will prefer ex-ante a rule of maximisation which is operationalised and implemented in a way that he is excluded a priori from the potential group of losers. Everybody will try to change a rule of maximisation ex-post to join the group of winners. The votes of all these persons will be on the market and available to political entrepreneurs who offer themselves as agents of special interest-groups.

Therefore we must expect similar tendencies to politicise a rule of maximisation in the field of medical goods and to transform this rule in a game of pure redistribution in favour of the ruling majorities. Taking into account the elementary importance of the goods at stake the dynamics against neutrality and impartiality and for an erosion of commitments to former agreements should be even more forceful. The slippery slope could be particularly steep.

Taking all aspects into account it seems to me that if we have good reasons for establishing an order of civil rights we also have good reasons for establishing an order of rights in the field of public health.

Let me finally consider very briefly what it could mean to establish a right-based allocation of limited medical resources. What could it mean to have the same right to medical treatment if unrestricted medical treatment is not available? Obviously it cannot mean that everybody has a right to the *best* treatment. But it could mean that everybody has an equal right to treatment of the *same quality*.

What this principle entails is fairly clear with regard to persons who suffer the same kind of illness. It is much less clear with regard to persons who suffer *different* kinds of illnesses. How can we measure whether the treatment of an influenza is of the same quality as the treatment of some type of cancer? But it does not seem entirely hopeless to make sense of the idea that different forms of medical treatment can have the same quality. One step in this direction would be to form classes of illnesses where they are differentiated, for example, according to their degree of danger, their typical impairment of life-quality or their consequences in the case of non-treatment. This would extend the sets of illnesses to which the criteria of equal treatment could be applied more or less straightforwardly. In a second step one can then try to compare the consequences for the different classes of illnesses if we have to make certain curtailments on an optimal treatment. Even if we cannot compare the quality of treatment for influenza with the quality of treatment for cancer directly we can perhaps do so with regard to the consequences it would have in both cases if some forms of possible treatment were *not* provided.

But there is another possibility to realise the idea of equal rights to medical treatment which perhaps sounds more convincing. According to this proposal a publicly funded health system would – within the limits of the given restrictions – offer different packages of medical treatment. These packages may differ considerably in the combination of medical services they offer. Some may put their main emphasis on a basic coverage for all types of illness whereas others may concen-

trate on an extensive treatment of severe diseases. Every citizen would obtain the right to choose one of those packages. In this way we would get rid of the difficult question what exactly is meant by the equal treatment of different diseases. We would interpret equal rights to medical treatment as equal rights to choose between different offers of medical treatment according to individual preferences.

I think that there are more and perhaps much better possibilities to realise the idea of an equal right to medical treatment. I do not feel obliged to make such proposals because all I have to presuppose for my considerations is that it is possible *in principle* to take the idea of an equal right to medical treatment as a meaningful guideline.

5 References

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