Specific ethical considerations relevant to resource allocation in healthcare

Maximising Welfare / Benefit

In considering how to make the best use of limited health care resources the focus of the decision shifts from the individual patient to a group of patients or potential patients, which may be the national population, a local community, or users of a specific service in an a hospital.

One ethical theory that lends itself to community or population level decisions is utilitarianism. For a utilitarian, the ethically correct action will be that which results in the maximum overall benefit.

Thus, in making decisions about health care this theory requires consideration of the benefit to be gained from the various competing options in terms of the improvement in health for an individual and also the number of individuals who could benefit.

In the context of the allocation of limited healthcare resources a key issue is the cost of the benefit achieved by the healthcare intervention. This approach would tend to favour resources being allocated to less expensive treatments or services that provide the greatest benefit. This may be a treatment that produces a large benefit for a small number of people or a small benefit for a large group of patients.

A criticism of this theory is that it fails to take into account the 'need' for healthcare intervention and relies rather on cost effectiveness.

The practical application of utilitarian theory in allocation of health care resources can be seen in the use of Quality Adjusted Life Years (QALYs) as a means of quantifying the net benefit from health care interventions to allow comparison of different interventions.

QALYS

QALY stands for **Q**uality **A**djusted **L**ife **Y**ear.

Alan Williams has described the thinking behind the development of QALYs thus:

"The essence of a QALY is that it takes a year of healthy life expectancy to be worth 1, but regards a year of unhealthy life expectancy as worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about)."

A. Williams, 'The Value of QALYs', Health and Social Service Journal July (1985), 3.

Health care interventions are measured both by the number of extra years of life, and by the increased quality of life, that they can achieve. Thus an intervention that provides 10 years of extra life at full health would have a QALY value of 10, and an intervention that improves quality of life from 0.5 to 0.8 for a person with a predicted further life expectancy of 30 years, would have a QALY value of 9. [0.3 (0.8-0.5) multiplied by 30]. Once the QALY value of a health care intervention is calculated and its cost is known it is then possible to calculate the **cost** per QALY of each intervention and provide a direct comparison between interventions. The general idea is that a high priority health care activity is one where the cost per QALY is as low as it can be.

Objections have been made against QALYs including the criticism that QALYs are ageist. Also many healthcare interventions are not the subject of a QALY

assessment and direct comparisons between the cost-effectiveness of different treatments is not possible.

Equity and Distributive Justice

A possible criticism of the utilitarian or QALY based approach to resource allocation is that it does not provide an equitable or fair way of distributing resources.
Aristotle, explaining his view of distributive justice, says, in effect, that equals should be treated equally, and unequals treated unequally in proportion to the relevant inequalities.
The utilitarian or QALY based approach could be said to treat unequals equally, in that it does not take account of differences in **need** for health care but focuses entirely on the **benefit** gained from an intervention.
Some individuals or groups of patients will have poorer health than others, or more serious diseases, and will have a greater need of health care. If degree of need is a main criterion, a just distribution of health care resources may require that these individuals or groups are allocated greater resources, even if the benefit gained by treatment is small compared to that achieved by a different treatment in patients who are less sick.
In the context of health care it could be argued that resources should be allocated to ensure that those in poorest health, or greatest need, are as well off, in terms of health, as they can be.

Patient Autonomy

To what extent should a patient's wishes regarding the choice of the course of treatment be respected?
In considering how to allocate scarce health care resources for the whole community, or for all patients with a particular condition, respect for the autonomy of a specific individual may conflict with other values such as equity or the need to benefit the whole community or group, or with the autonomous choices of other individuals.
Does respecting a person's autonomy to make decisions about their treatment mean that they should be able to choose an expensive treatment over a cheaper treatment? If the consequence of complying with such a choice is that treatment will be unavailable to other patients because of the limited available resources this may not be fair.
A balance needs to be struck between respect for individual autonomy, benefiting the whole population and fair distribution of limited resources.
This is taken from a more detailed discussion of ethical issues of resource allocation to be found on the UK Clinical Ethics Network website: Ethical Issues-Resource Allocation in Health Care
http://www.ethics-network.org.uk.