CHAPTER IV

HEALTH POLICY AND THE FUNCTIONS OF HEALTH CARE

Health Policy in Germany

The analysis of justice in health care I presented, in principle, supports the political call for securing access to the central forms of health care for everybody. Access must be such that everyone has the means to get the health care he is entitled to through the central functions. Formal access which cannot be taken advantage of because one cannot afford to pay does not count for much when we are sincerely interested to sustain the moral agency of others and ourselves.

Impartial Kantian justice leaves open the question of how health care is to be provided and how the health care of those who cannot pay for themselves should be financed. The only restraints which need to be observed are that the provision of health care is effective and that its payment does not put high enough a burden on the socio-economically worst-off that they will as a result have less than adequate incomes.

These two constraints decide neither between the most important currently competing models of health care provision nor payment systems. In the provision of health care models of what is called "*managed care*" and "*fee-for-service*" medicine are the two most important approaches. In managed care, the primary provider of health care is an institution, not a physician. Within this institution, usually a so called "*health maintenance organization*" (HMO), employed physicians distribute services among patients according to the rules and criteria of the institution. Managed care is becoming the dominant model of provision in the U.S.. In contrast, in Germany micro-allocations are made fairly autonomously by individual physicians who are generally working on a fee-for-service basis, and only in hospitals micro-allocations are made according to institutional rules. However, both models of provision are, in principle, capable of distributing services in a way that the central functions of health care are not sacrificed for the peripheral functions, as long as providers recognize the moral importance of this division.

In Germany, physicians in ambulatory care currently work with a more or less fixed budget per office which can be distributed by the physicians among patients and a variety of services in almost any possible way. Thus, there is little or no principles of micro-allocation which are binding for a physician. I would argue that principles of micro-allocation, however, are extremely important for a just health care distribution. Without such principles, even an impartially just total budget can be too high and too low at the same time. It can be too high for the peripheral functions of health care and too low for the central functions.

This unjust distribution appears to be the case in Germany in the sector of ambulatory care. Germany, together with Japan, has the highest number of physician-office visits, averaging 11 visits per person per year (in comparison the U.S. has only 6 visits). Most of these visits concern minor ailments such as mild headaches, infections, or the renewal of standing prescriptions. In contrast, potentially life-saving and disability-preventing health services appear to be much underused.

To give just one example, Germany (unlike the U.S or the United Kingdom) does not have a national program for heart disease prevention which could be implemented through the high number of yearly office visits. Mainly for that reason, Germany has not seen a comparable reduction in mortality from myocardial infarction (only one fourth of what was achieved in the U.S. during the last 20 years). The situation is similar for cancer, where the U.S. has recently achieved a decline in breast cancer (incidence and mortality) through implementing large screening programs whereas in Germany the incidence of breast cancer is still rising.

Within the existing budget in ambulatory care, a shift towards the central functions of health care appears to be both possible and necessary in Germany, and the prevention of cardiovascular diseases and cancer would appear to be the two most important goals. This should possibly include a shift towards spending less on the slightly life-prolonging less effective treatments of chronic diseases in old age towards preventing and treating these and acute diseases among those who develop them fairly early in life.

On a different micro-allocation issue Germany is doing quite well in comparison to almost any other health care system including Canada and England. The system, in general, does not offer better or more extensive central health care to better-off socio-economic groups, which is in agreement with my analysis. To save the moral agency of others is of equal importance regardless of whether a person is rich or poor. The main reason why the care is distributed equally is a fairly homogenous fee-schedule for physicians which allows the better-off to pay only slightly more of what the worst-off pay, that is not permitting the better-off to pay more than the regulated fee privately. This fee-schedule is binding for almost all German physicians. Those who are not prepared to comply with it can only treat the 1 percent of Germans who are not insured. Thus, there is only very little financial incentive to treat the better-off differently, and there is, in fact, some reason to believe that they sometimes experience inferior services. Those sickness funds that insure the general population (*"statutory sickness funds"*, covering more than 85% of the population) require more rigorous training from licensed physicians for some services, such as ultrasound examinations, than private insurance companies do.[55] It generally cannot be said that the system disadvantages the poor through lower quality of care or less than equal access.

The way the system is financed also does not appear to be grossly unfair and may meet the requirements of my ethical analysis. The system is unlike the British system not tax financed but financed through insurance contributions that are made in equal parts by those who are employed and their employers, covering all family members of the employed person. The insurance rate is fixed (on average, about 12% of the total wage), and therefore contributions rise with income. At an income level of what amounts to upper- and middle-class incomes the contributions do not rise anymore, however. This is meant to keep the better-off socio-economic groups in society within the statutory sickness funds and not let the private insurance sector grow significantly beyond

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[55] Michael Arnold, University of Tübingen, (personal communication)

10% of the population. The socio-economically better-off are perceived as politically essential for maintaining or improving the quality of care in the whole system, and a more progressive mode of financing the system is supposed to harm those who have no alternative of leaving it. To the extent that this assumption is true, this move appears to be justified on the grounds that it is better than any alternative for those prone to early death and disability and, at the same time, does not place too heavy a burden on the poor.

The total budget of the health care system in Germany is currently about 9.1%, and the government has enforced strict cost-containment rules through a series of reforms which do not allow the systen to go beyond this level. In contrast to the U.S., Germany has succeeded in controlling its health care costs through the last 18 years when the first cost-containment bill was passed. The question is, however, if this budget is adequate for a country with this level of resources available.

In one sense, the budget is clearly inadequate. It has not prevented that about 30% of the population dies before the age of 65. In Germany, only a minority of blue-collar workers stay healthy enough to work until the officially recognized retirement age of 65 years. The average retirement age is by now about 57 years for workers, with most of them retiring involuntarily because of disabling chronic diseases. It is therefore the case that a majority of workers cannot enjoy what is recognized as a normal work-life because of premature death or severe disablility. This is in contrast to what the higher ranks of white-collar employees and professionals can expect, many of them even being able and permitted to work beyond the official retirement age of 65.

It is clearly inappropriate that the government has so far sponsored little research into the determinants of these differences. It is only known that mortality and morbidity for some diseases are higher among blue-collar workers and among lower socio-economic groups in general, for example, but to what extent this explains the observed differences in life-expectancy is not known. It is also unknown to what degree the health care system could address these differences, and how much resources such an attempt would take. It appears doubtful that these differences can be significantly ameliorated through shifting from the peripheral functions of health care to the central functions alone, however.

Since working to the officially recognized retirement age is a very central ideal of the good in Germany, a country which distributes many social benefits (material and immaterial, such as public recognition) through the working process, it would be unjust to leave those differences to good health policy alone without regarding them as matters of respecting others as moral agents. If it was indeed the case that a higher budget for health care would allow more people to work until the official retirement age, the government's strict enforcement of the current cost-containment policies may be ethically indefensible.

I am here not suggesting that the officially recognized retirement age should be taken as that age which is sufficient to allow everyone (or even most people) to fulfill their life-plans. I suspect that most life-plans in Germany currently go somewhat beyond that age. But in order to be conservative about my assumptions of what age is adequate, I have presented the case for the very widely held ideal of the good of a complete work-life in Germany. It appears that the current budget for health care cannot guarantee that even this age is reached by as many people as possible.

Furthermore, I also do not want to imply that health care is the only or the best means to achieve that goal. I am convinced that it could have a great impact, in particular through preventive medicine. But I also recognize the importance of working conditions and socio-cultural factors such as attitudes towards health. Not all of these factors are equally worthy af attention for purposes of justice. To the extent that people choose freely to assume more risky life-styles (such as dangerous sports or eating habits), it appears that those behaviors which are an important component of the ideal of the good which a person has accepted may be beyond the most immediate concerns of justice. They rarely are no matter of justice at all, however, because to the extent that I risk my own life I also fail to be able to support those who depend on me. I have tried to argue above that this includes more than those with whom I am in direct and voluntary relationships. It should also include those who without the institutions I am able to support cannot continue to survive as moral agents.

It is the case in Germany now that the socio-economically worst-off groups have an income that allows them to pursue a wide range of life-plans, since the welfare system provides fairly generous benefits, including free health care which is equal to what everyone else gets. The most serious exception to this quite general claim are those who are unemployed in the long run. Although they enjoy adequate material benefits which allow for complete moral agency, they are not at a high level of capability that can only be realized through employment. I consider this to be a very important problem of social justice in Germany.

It is, therefore, an important empirical issue whether the health care budget can be raised without causing higher levels of unemployment, and whether the capability reducing consequences of unemployment can effectively be ameliorated through government efforts to reduce long-term unemployment. In general, however, I believe that Germany could increase its current health care budget without putting burdens on the worst-off which would reduce their capabilities below an adequate level.

Even if the health care budget could not be increased without raising unemployment, there appears to be an obligation to do so if it was shown to be effective. The reason is that those who are unmemployed but have an adequate income still have a wide range of ideals of the good available that can be considered adequate. They can engage in highly recognized voluntary projects, participate in politics and culture, raise a family, or develop private projects.

All of this is possible because of the generally generous welfare system which provides free education (including university education), health care, housing, and the public financing of political or community activities. To the extent that an increase in the health care expenditures would put these benefits also at risk, it might in fact reduce the worst-off to less than an adequate level of capabilities.

It is beyond the scope of this analysis to predict at what percentage of the gross national product (GNP) spent on health care this point would be reached, although the strict limitation of expenditures currently enforced by the government together with a total lack of interest in targetting the expenditures at the central functions of health care seem to be the two biggest ethical problems for the allocation of resources in the German health care system.

Health Policy in the United States

In the United States, only the elderly and the socio-economically worst-off enjoy a right to health care which covers many of the central functions. The Medicare and Medicaid programs do not cover the whole population, and most of those who are in the age-range that is central for fulfilling life-plans are either privately insured or not insured at all. In case they require care which they cannot pay for either through insurance or directly, they have no entitlement against the state for coverage. Although any American is normally in a position to get some care in case of emergencies, even life-saving or disability-preventing elective services can be denied to those who are not able to pay.

The dependency of the extent and quality of all types of care on the ability to pay is clearly unjust since it includes the central functions of health care. It implies that society is not prepared to make the sacrifices necessary to save the moral agency of those who cannot provide for their own health care or have in the past chosen not to do so. Although we would not have an obligation to provide those with resources that have chosen to squander (or not to insure against bad luck) their assets, at least beyond a minimally adequate level of welfare, we cannot leave unattended those who chose not to take out health insurance although they could have done so from their income. Instead, we should not allow anyone to be uninsured, since it is part of the human condition that we can come into situations where we are not appropriately insured and would will to be treated nevertheless. It appears that we should not allow anyone to not be insured against premature death and severe disability at least, although everyone should be free to not make use of the services covered through their insurance in case of illness.

As in the U.S. they do, the better-off should in principle have an opportunity to buy a more extensive coverage for the central functions. This is a right they enjoy as part of their basic liberties. On the other hand, the state can regulate the market for additional insurance if this benfits the central health care of those who are at the highest risk of premature death or illness, regardless of whether they are rich or poor. In Germany, it has been made difficult (but not impossible) for the better-off to buy better care in order to rise the standard coverage to the highest possible level of quality. In the U.S., the negative impact of making it easy for the better-off to leave the insurance system that covers most people on the quality of care of those who cannot opt out of the public system is not sufficiently recognized in the health policy debate, and needs to be taken into consideration when solutions for covering everyone with insurance for the central functions of health care are sought.

Similar to Germany, micro-allocations in the U.S. are often not deliberately targetted at the central functions of health care. However, this appears to be happening to a greater extent than in Germany. Most HMO's do not cover the treatments of those minor ailments that consume a large part of Germany's ambulatory care resources, such as headaches or minor infections. Also, managed care has put some focus on the outcomes of treatments in order to improve the quality of care. Such studies rarely enter German ambulatory care practices, and are also less frequently part of hospital micro-allocations than in the U.S..

Obviously, these comparisons are not meant to substitute for detailed empirical studies. Instead, I make them to show in what way a general theoretical approach to justice in health care ccould have substantive implications that allow for the normative comparison of health care systems. It allows us, for example, to determine what kind of research is necessary to further just health care allocations. Studies that analyze the outcomes of treatments on survival and the ability to function emerge as particularly important. The U.S. is world-wide the leading undertaker of such studies, which include studies regarding the outcomes of preventive interventions. A focus on the total health care budget and on ways of financing this budget has dominated the discussion in justice in health care in Germany, leaving aside important issues of micro-allocation. This has helped to cause a relative lack of studies that would allow one to implement a more just micro-allocation in Germany. In the U.S., in contrast, such research has been done, although not because it has been thought to be important for purposes of social justice.

Because the practice of physicians in the U.S. is far more regulated than in Germany (with no managed care, few guidelines for treatment from speciality-associations, and very little malpractice litigation) and because of the relative abundance of outcomes studies of different treatments in the U.S., a shift towards a more just micro-allocation pattern appears to be more feasible currently than in Germany. This is a very important opportunity, because the total budget spent on health care in the U.S. is quite large and estimated at about 14% of the GNP. A shift of resources within this fairly large budget towards the central functions of health care would presumably have considerable impact.

The assessment of the adequacy of the total budget for health care in the U.S. is quite difficult. It has been estimated that about 20% of children are currently put at risk by hunger and poverty. Also, the quality of public education and the housing conditions of the poor are often not adequate. To the extent that these generalizations are true, the socio-economically worst-off do not obviously enjoy the level of resources which is adequate even for complete moral agency. On the other hand, long-term unemployment appears to be somewhat less of a problem. It is important for economists to study whether these conditions can be improved while at the same time making available and improving the central functions of health care for everyone. Since the GNP of the U.S. is still slightly higher than that of Germany or Sweden, countries in which these twin goals have been achieved to a much higher degree, I suspect that through structural and redistribu-tional interventions by the government such changes are in principle feasible, although I cannot make this case myself.

In the U.S., there is even more pluralism of ideals of the good than in Germany, and the tentative claims I made about the central importance of a full work-life for most Germans cannot be made here. This may undermine any attempt to construct a minimum age which can be accepted by most for being able to pursue typical life-plans. Still, I believe that such a construction is possible. This is so because despite the pluralism of ideals of the good, there is actually very few which extend into old age. Many Americans begin new life-plans after retirement, such as moving to a different part of the country or beginning new professions or educations. Although these initiatives are very encouraging since they change the often painful experiences of getting older in society, they do not give rise to health care entitlements of equal moral importance than of those who have had little or no chance for pursuing their first set. Since there is a wide variety of life-plans that can be fulfilled without having to live into old age, and only very few that extend into old age, the case for not setting the age limit for the central functions appears not to be weakened by the pluralism typical of U.S. society.

A clear articulation of what the most important entitlements are for purposes of justice seems to be a crucial element for furthering the debate about health care reform in the U.S. Many opponents of universal health care coverage of the population liken health care to other goods of consumption. For some health services, I think this comparison is adequate. Concerning the health care with minimal or no functional implications, it is difficult to give criteria that would distinguish health care from often quality-of-life improving commodities. The impartial reasons for universal coverage can be better articulated by not speaking about health care per se but about what I called the central functions. This is a better strategy than calling for a "*basic minimum*" of health care, which gives little or no focus for what should be covered. To campaign for the kind of health care which allows as many Americans as possible to fulfill their life-plans gives a clear and compelling reason why central health care is so important. A basic minimum can address many health differences between people, not all of them equally matters of justice.

Cost-Effectiveness and Justice in Health Care

Cost-effectiveness studies are another example of research important for just micro-allocations. Like in outcome studies, the U.S. is far ahead in this field in comparison to Germany. Although in one sense the costs of health care services to restore or maintain moral agency are a morally arbitrary factor, there are impartial considerations that can urge us to consider them as being morally relevant for just micro-allocations. The intuition of moral arbitrariness can be expressed through the question of why someone's priority rank on a list for health care entitlements should depend on the costs of the service one needs, rather than the nature of the health problem it addresses alone.[56] One may argue that equally significant losses in capabilities should count as equally important morally, even if they involve for their treatment or their prevention quite unequal costs.[57] I think that this intuition is true. There appears to be an even more disquieting concern about cost-effectiveness analysis when the costs of health services vary for quite arbitrary or even morally suspect reasons, such as the high profits in parts of the health care industry or lack of government interest in the development of a cheaper treatment for a disease, e.g., since the majority of the population is not likely to develop it.

My argument for nevertheless allowing the costs to play a morally significant role moves in two steps. The first step is to demand that cost differences that are due to unfairness in other social institutions should not count. Such

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[56] Rawles (1989)

[57] Brock (1993)

unfairness is for example given if the differences in cost are due to deliberate neglect of research into specific diseases for morally unacceptable reasons, such as discrimination by scientific institutions or the government as a research sponsor. Examples for this include racial or gender discrimination through not funding research into certain diseases. It has e.g. been argued that the cost-effectiveness of coronary bypass-surgery of women is often lower than that for men because the technology was developed through research done mostly for and with men in a climate in which the diseases of men were supposed to be more important to cure. If women were now excluded from this health service because of lower cost-effectiveness, they would be unfairly harmed.

Although it can be very difficult in practice to determine cost differences as unfair, the idea should not immediately be dropped since it can be a useful concept, for example when it is invoked for directing our research funds. It stresses the importance of using research funds in a way that all groups in society are fairly represented, since those who are underrepresented may be disadvantaged twice: first since there is less choice of treatment for them, and secondly, the existing treatments may be of low cost-effectiveness and, thus, not be covered by insurance. Furthermore, from this perspective we can see the contribution to social justice which research can make that aims at particularly cost-effective treatments rather than at treatments which are maximally effective but are extremely costly.

The second step in the argument towards the inclusion of cost-effectiveness as a moral factor in ranking the priority of health services for the central functions of health care is a consideration of impartial agreement among those at risk of premature death or loss of moral agency. If the total budget for that purpose is set at an ethically adequate level and the existing cost-effectiveness differences are not due to morally objectionable causes, it seems prima facie fair within the group of the potential beneficiaries to attempt to maximize the total number of life-years that could be saved. This is so because everyone in that group of people stands to lose the same, namely the basic capabilities of moral agency, and there are no morally inadmissible trade-offs with other social goods involved.

On reflection, we seem to intuitively agree that cost-effectiveness ranking in such a situation can be a morally important determinant for which health services we should publicly finance. The reason is that within the group of those at risk of losing their basic capabilities, to maximize the aggregate benefit can be seen as a demand of fairness itself. If we were to squander resources available for that group, let us say through determining whom to save through a lottery, we had acted unfairly to those who would have been saved the loss of moral agency if we had used a maximizing strategy. This is so because if the members of that group had been asked before knowing where they would be placed with their disease in a cost-effectiveness ranking, they would have objected to the principle of a lottery which would reduce theirs and others' chances of rescue. At the same time, no one could have rejected an ex ante maximizing strategy, since for everyone the same kind of loss was at stake.

In this specific context, impartial ex ante reasoning appears to be morally acceptable since it does not violate the categorical imperative. Any ex ante chosen distributional principle by those who face the premature loss of moral agency will later be regretted by those who are put to a disadvantage by it. But contrary to a situation where a fair budget has not been allocated, no further sacrifices by anyone can be expected, and maximizing the yield of the budget does not reduce anyone's just entitlements.

There are, however, some complexities here which I can only mention rather than discuss in detail. One is the question if the prima facie intuition that we should maximize the number of life years with moral agency is ultimately defensible. How should we, for example, think of cases where we can either add little life-expectancy for many versus a lot of life-expectancy for a few? What role does it play at what age moral agency is lost prematurely?

The objections against cost-effectiveness analysis that are usually brought forward when it is used for prioritizing health care services either concern the complete lack of any explicit distributional considerations, e.g. when the technique is justified for purely utilitarian reasons, or they concern the non-permissible comparison of social goods of different moral importance, as happened when the first version of the Oregon Health Plan was introduced. In that version, some expensive life-saving procedures ranked lower than inexpensive pain-reducing procedures. Thus, tooth-capping was given priority over appendectomies. It cannot be justified, however, as Dworkin persuasively argued, to allow a young individual to die from appendicitis which can be cured without remaining disability through surgery by putting the money into a large number of capped teeth.[58] The reason for this also follows from the presented analysis: to allow an individual to die extinguishes not only his future experien-ces of pain-free life but also the human being as a moral agent, a loss that could clearly be rejected by the indivi-dual in question if all that could be gained through

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[58] Dworkin (1993)

his sacrifice was to save others from temporary pain and a loss of teeth.[59]

As with outcome studies, cost-effectiveness analysis therefore emerges as a very important instrument of a just micro-allocation. It has many ethical pitfalls, however, when it is used. From what I have said above, it is clear that it cannot substitute for principles of justice in micro-allocations, it can only help to implement them. Services with equal cost-effectiveness measured in *"quality-adjusted-life-years"*, for example, are not equally important from a moral point of view if they address different age-groups, or concern the same age-groups but remove reductions in the quality of life in different ways. In general, those services, other things being equal, that address younger age-groups and more functional aspects of the quality of life should be given some priority. To go beyond these general remarks, however, would require a discussion of specific cases since more specific general criteria do not appear to be available. I will, however, comment on the use of quality of life in cost-effectiveness analysis and when it is used in the disabled for a just micro-allocation of the central health care services.

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[59] Rawles (1989)

Saving Moral Agency in the Disabled

The arguments I have made above about the moral importance of avoiding the premature loss of moral agency can be said to hold by and large independently of the levels of well-being a person has achieved or is likely to achieve in the future. The central functions of health care should address those who, in principle, can pursue life-plans regardless of their subjectice quality of life. This implies that they do not cover those who have no chance to achieve the level of functioning needed to do that, such as the permanently and totally incompetent or miserable. I want to emphasize, however, that this does not imply that the lives of those human beings should not be saved, since there are other important moral reasons to save them[60].

I will now more explicitly argue why we should not determine what lives should be saved from death or loss of moral agency according to how far they go beyond a minimum of functioning needed for moral agency or how desirable these lives are.

I have argued above that in the group of services which avoid premature death and the loss of moral agency we should allocate health care in ways that are most cost-effective. It

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[60] Brock (1993)

initially appears intuitively right to consider quality-of-life and disabilities in these cost-effectiveness calculations. One way to start the argument for including the quality-of-life in deciding whose life or moral agency should be saved is to say that there are states that are "worse than death" that would clearly not warrant being maintained. As this shows, quality-of-life is a matter of degree, and it appears not to be plausible to not consider differences in quality-of-life at any level which is somewhat better than "worse than death" for the allocation of resources.[61]

This reasoning is false, however, since it only makes sense to say of someone else's life that it is in a state "worse than death" if it not only is miserable for the individual himself, say through great discomfort or pain, but that additionally the person has lost the minimum level of mental and physical functioning needed for moral agency. This is so because there is a sense in which a life of residual moral agency cannot be worse than death interpersonally. We cannot have an interpersonal standard for trading-off moral agency for well-being experience and, therefore, also cannot make the claim that someone else's life is "worse than death" if it still allows for moral agency. Well-being depends on the ideal of the good a person has chosen, whereas moral agency does not. Furthermore, well-being includes more than

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[61] Glover (1977)

experiences. For a person for whom a life in extreme pain still contributes to the fulfillment of his meaning in life, life may be going well although his experiences are miserable. To not save the life of such a person because we do not share the judgement or cannot even imagine that his life still goes well can be unjust as long as we can still recognize him as a moral agent.

This may even support health care entitlements if we can say that the experiences this life still allows are worse than no experiences at all even from the standpoint of the individual concerned. Not all ideals of the good even have a concern for experienced well-being. Extreme stoicism in principle could be indifferent about this dimension. Ruling that those who do still care for their own survival, but face an extremely low level of experiences should have lower priority would, in effect, discriminate against their ideals of the good. Because of its special value, moral agency should be protected quite independently of considerations of ideals of the good, including ideals that imply that health is only of moral importance to the extent that it avoids bad and promotes good experiences.

Kantian ethics, therefore, supports the idea that the kind of health care which sustains human agency should be distributed in an entirely egalitarian way. The protection of the basic capabilities of everybody should morally count equally for the state. Kantian ethics arrives at this egalitarian claim through recognizing that the most distinguishing human characteristic, moral agency, is the most valuable asset of everyone and is distributed equally among people, regardless of whether a person is happy or unhappy, rich or poor, privileged or disadvantaged, disabled or not. If moral agency does not come by degrees, and is a sufficient reason for entitlements through the central functions of health care, these entitlements should not be diminished because of existing disabilities or impairments that still allow for moral agency.

As Bernard Williams observed, identifying the morally most important characteristic is one of the reasons why Kantian ethics has found wide resonance in common sense morality[62]. If this characteristic was available only for a few, it would be hard to justify why we should respect everybody as a free and equal citizen, which is the aspiration of modern democracies. Those who de facto lack moral agency are also worthy of respect because they are also human beings, although they temporarily or always lack the means of realizing the capacities that are needed to be a free and equal citizen. Amartya Sen has made the argument that equal respect for everybody as a moral agent is a

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[62] Williams (1985)

feature of all of the currently competing moral theories. He attributes this to the force of the Kantian idea that the expression of equal moral concern for others is what morality is about[63]. In health care this implies that the kind of care which is directed at saving moral agency should also not depend on features external to moral agency itself. To the extent that we allow this to happen, e.g. through favoring those who are more productive or enjoy a higher quality of life, we do not treat people as equals in a morally central aspect.

For cost-effectiveness analysis, this implies that for the central functions of health care we should focus on "*life-years-gained-allowing-for-moral-agency*", irrespective of their quality. This addresses life-years that are gained because we avert death or severe disability. I cannot further the question here of what should count as severe disability, but it is clear that the focus should be on gross functional impairments rather than on disabilities that insignificantly reduce someone's choices of the good.

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[63] Sen (1992)