JUSTICE AND THE FUNCTIONS OF HEALTH CARE

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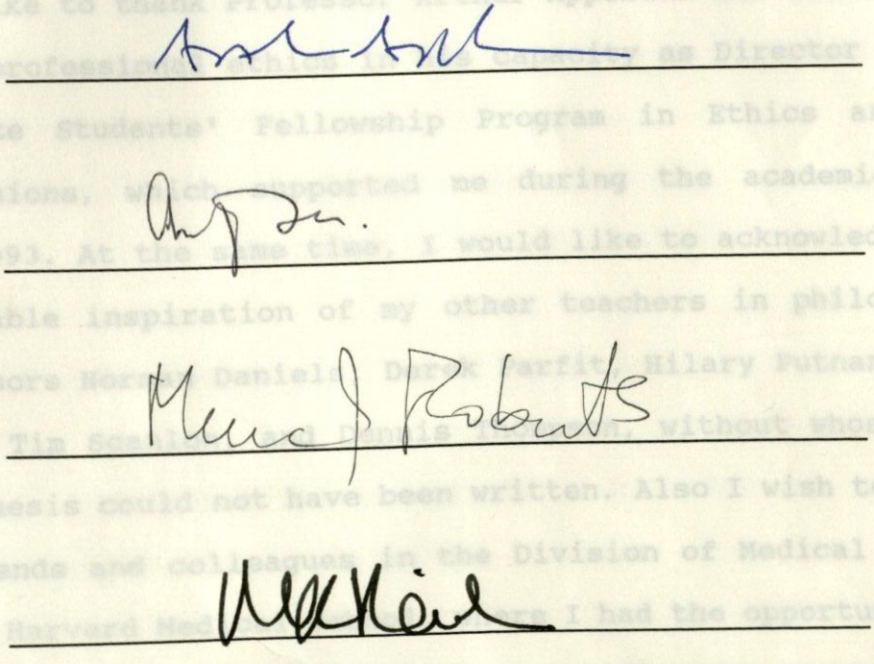

PREFACE

This thesis was written under the supervision of Professor Marc Roberts who, some years ago, encouraged me to take on this subject, and since then has tutored me as a teacher and friend to its completion. I had the privilege of countless discussions with him about ethics and health policy, each of which teaching me something new. His support was extremely generous, and has greatly indebted me to him. I am similarly indebted to the other members of my research committee, to Professors Arthur Applbaum, Michael Reich, and Amartya Sen, who provided important comments and criticisms which profoundly influenced the development of my thoughts. I would also like to thank Professor Arthur Applbaum for teaching me about professional ethics in his capacity as Director of the Graduate Students' Fellowship Program in Ethics and the Professions, which supported me during the academic year 1992-1993. At the same time, I would like to acknowledge the invaluable inspiration of my other teachers in philosophy, Professors Norman Daniels, Derek Parfit, Hilary Putnam, John Rawls, Tim Scanlon, and Dennis Thompson, without whose work this thesis could not have been written. Also I wish to thank my friends and colleagues in the Division of Medical Ethics at the Harvard Medical School, where I had the opportunity to discuss my ideas and received many valuable suggestions. Finally, I would like to name my most important sources of support, my companion Angela, and Carl-Stanley and Rosa-Lena,

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TABLE OF CONTENTS

INTRODUCTION

Determining the moral value of saving lives through postponing death and sustaining life's basic qualities involves reconciling two opposing intuitions. The first is that saving lives is morally so important, in particular when young and identifiable individuals are at risk, that the value of doing so cannot even be expressed in monetary terms. Instead, we seem to have an unlimited obligation to save lives if we can do so at no risk to our own life and only monetary costs are involved. The conflicting intuition is that we do not value life for its own sake. Instead, life gets much of its moral value through experiences, which make it valuable to the individual whose life it is and to others who share these experiences. Those experiences, in turn, depend on, among other things, the resources we as individuals have available. Thus, it seems appropriate to determine how much to spend for life saving in the context of making all the other expenditure decisions that we face.

The first intuition pulls us in the direction of insulating our obligation to save lives from the obligations we have for assuring a fair distribution of resources. The second intuition would make protection against the loss of life and life threatening illness part of what everyone may or may not want to buy once we have guaranteed a fair

distribution of resources. What we consider to be a fair share of resources of course depends on the more general conception of social justice that we accept. Thus, the question is if our obligation for health care provision is prior to, or secondary to, other social obligations.

Both of these positions are well represented in the literature on justice. An example of making all health care an insulated social good of special moral importance is provided by Norman Daniels' book Just Health Care.[1] Daniels justifies a right to health care for every citizen in a country as affluent as the U.S. because of its central importance for "*equality of opportunity*". He concludes that health care should be distributed according to people's medical needs and not through the free market from an individual's fair share of income.

The alternative position is defended by Allan Gibbard[2] and Ronald Dworkin.[3] They both argue, although from different conceptions of social justice, that justice in health care requires that all forms of health care should be subject to fair entitlements of resources and reflect an individual's preferences for health care including health insurance.

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1 Daniels (1985)

2 Gibbard (1983)

3 Dworkin (1993)

The first approach seems, correctly, to insulate someone's survival prospects from the distribution of income, however, it also seems to go too far, because it would insulate all health care from decisions about what insurance we would voluntarily purchase if we had a fair share of income. It is not plausible to argue that every form of health care, including for example health care that merely slightly enhances the quality-of-life, is more important than all other social goods which might enhance the quality-of-life of the same person more effectively.[4] On the other hand, the first approach also needs to be supplemented with a principled way to set limits to society's obligation to spend resources on health care. Otherwise we might have to spend all we have just for saving lives. The second proposal does give such limits. But it does not, in principle, distinguish among different forms of health care. Moreover, it cannot accommodate the intuition that the availability of some forms of health care should not depend on what we would choose once we had a fair share of income.

I will argue that, from an impartial point of view, the prevention of premature loss of life and the preservation of a minimum level of mental and physical functioning should be the morally central functions of health care. They should not be subject to a fair distribution of income but be protected

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4 Buchanan (1983)

by entitlements which are set by principles that are impartially acceptable, including principles governing the limits of these entitlements. I will propose that we should use a particular set of impartially justified principles of justice to guide the distribution of those resources that determine our survival prospects and our ability to take part in the moral life. In particular, I will argue that such entitlements should not be viewed as a means to maximize the general welfare in society or as the expression of its accepted community values, as is suggested by utilitarian and communitarian approaches to this issue.

My effort is guided by a broadly Kantian understanding of moral reasoning which I will develop in Chapter II and apply in the remaining chapters. The most successful of all recent Kantian theories of justice is, of course, John Rawls' attempt to apply Kantian moral reasoning to the broadest issues of justice in society, the justice of basic institutions.[5] Although Rawls does not endorse the link between rationality and autonomy that Kant proposed, the method of moral reasoning employed by Rawls in A Theory of Justice is basically Kantian. I will draw several key ideas from Rawls' work, including the idea of the importance of life plans for defining moral agency.

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5 Rawls (1971)

Finally, I will draw on Amartya Sen's recent work on equality because of its importance for understanding the comparative advantages of different people.[6] I will argue that to allow for some minimum physical and mental functioning, as well as for the survival for an appropriate life-span, are morally the most important tasks of health care and should be separated in priority rankings from the distribution of other health care services or other social goods. To do this, I will use Sen's concept of a "*capability set*" to help define the central functions of health care. This will allow me to give content to the key notion which, from a Kantian point of view, insulates the central functions of health care, namely the notion of moral agency. Furthermore, the method I suggest for deciding what the total budget for the morally central functions of health care should be will involve an analysis of the effects of various choices on the distribution of capabilities. This is in contrast to what is normally suggested for such purposes, namely welfare trade-offs.

The health policy significance of this essay can be seen in at least four aspects. The first concerns the debate about the question if there is a right to health care.[7] Although I do not take up this issue comprehensively, since I

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6 Sen (1985),(1990),(1992); Nussbaum & Sen (1992)

7 Buchanan (1983)

will not address the question if the morally most important functions of health care should lead to entitlements protected by individual rights, my analysis is quite compatible with such a claim. Instead of focussing on rights, I will focus on the obligations we do have to ourselves and to others. It is a separate question which I will not consider if such obligations should be enforced through rights or not. The answer to that question depends on issues that go beyond justice in health care and concern the institutional framework of justice in society more generally.

It is also important to recognize that I do not wish to imply that there should not be any rights to health care apart from the central functions. I only argue that if there are such rights, their corresponding obligations need to be argued for using a different set of principles than those that define and justify our relationship to the central functions of health care.

The second debate in health policy on which this essay touches is the attempt to specify a "*basic minimum*" of health care to which everyone should be entitled, regardless of whether such an entitlement should be a matter of rights or not.[8] It has often been argued that the idea of a "*basic minimum*" is essentially meaningless because there cannot be

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8 Gibbard (1983); Buchanan (1983)

an ethically defensible way to define that basic minimum. Although I am not taking on the task of constructing a basic minimum here, I at least attempt an ethically defensible substantive definition for the central functions of health care that should be included in whatever we define the basic minimum to be. One way to conceive of a basic minimum is to combine the entitlements of the central functions of health care with what we impartially believe should be provided to everyone given some of the obligations we have in related domains of justice, such as a fair income distribution.

Third, this essay does give us reason to consider whether there are constraints on the ethically defensible uses of policy analysis for ranking the moral importance of health care services.[9] I will explicitly argue that when we use policy analysis to evaluate some health care services, we should not discount the moral value of lives according to their expected lower quality-of-life or their level of disability, as long as these lives still allow for moral agency. I will also plead for the ethical rejection of comparing the moral value of some life-saving services with health care services which are important for other reasons. However, I will claim that cost-effectiveness has an important role in determining which life-saving services we should fund as part of our obligations to others with respect

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9 Brock (1992)

to the ethically most central functions of health care.

The final health policy issue for which this project seems relevant is the permissibility of age-rationing.[10] Again, I will not address this problem directly. However, my criteria for defining and justifying the morally most central functions of health care will use age and life-expectancy as morally significant proxies. The reasons why age and life-expectancy do matter are moral reasons, which are largely independent of the idea of the good we accept. I will make the claim that they should be regarded as morally important for the rationing of some health care resources largely independent of the economic ramifications or the social acceptability of doing so in terms of the predominating ideas of the good in a society.

I present my analysis in four chapters. In the first chapter, I will provide some of the empirical facts relevant to a treatment of the ethical issues involved. It is important for us to recognize that our potential for saving lives from premature death and illness is constantly growing due to improved technology and that we could spend virtually unlimited resources for that purpose while continuing to gain some small benefits. This increase only aggravates a critical ethical problem, namely how to compare the moral importance

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10 Daniels (1988)

of avoiding premature death and preventing some especially debilitating premature illnesses with other functions of the health care system.

In Chapter II, I will develop my methodological resources. The main idea is that Kantian ethics gives us the right account of why we should be concerned with the survival prospects of other human beings, namely that it is an obligation which is part of respecting others as moral agents. In order to be able to conceive of an ethically meaningful currency in which both the benefits and the costs of discharging this obligation can be expressed I will make use of Amartya Sen's concept of "capabilities". I will argue that the central functions of health care, from an ethical point of view, concern those capabilities that allow us to function as moral agents.

In Chapter III, the main distributional claims for the ethically central functions of health care are introduced, as they follow from Chapters I and II. I make the case for principles that allow for setting an ethically defensible budget for the purpose of preventing premature death and loss of moral agency, and explain what this would imply for health policy and the distribution of income in a just society. This is an attempt to move us towards a reconciliation of the two intuitions I presented above, namely that some functions of

health care are morally special but that they should still not be permitted to consume all of our resources.

In Chapter IV, I will apply my analysis to the health care systems in Germany and the United States. I will show that the central functions of health care are not adequately served in either country, mostly because of micro-allocation problems. Furthermore, the total budgets on health care in both countries appear to be determined by the wrong kind of considerations. Finally, I will comment on the potential use and misuse of cost-effectiveness analysis for allocating health services within a fair health care budget.