A philosophical approach to rationing

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MEDICINE, LIKE MANY COMPLEX SOCIAL ACTIVITIES, is pulled in two moral directions. Its most apparent first concern is to care for the individual. But doctors function within society, and while communal interests include protection of the individual, an equally compelling political agenda of Western democracies is the distribution of goods, services, and opportunities as freely and equitably as possible for the common good. Social policy debates what is "free", "equitable" and "good", and medical social policy is simply a subset of those politics. So the healthcare system must arrive at a balance between these potentially competing demands. These matters — access, prioritisation, distribution — are always adjudicated within financial budgets and political contingencies. Restrictions apply; limits must be heeded; pinching in one place loosens another.

In both the United States and Australia, the "R word", rationing, is only quietly uttered, apparently somehow to dodge the sanctimonious bay of those who would "protect" the patient.[1] The moral rejoinder is almost always, "because of the sanctity of life, each and every patient is entitled to the full recourse of medical intervention." I deny that assertion, both because it betrays the reality of medical practice (ie, the current distribution of limited resources) and because it falsifies medicine's moral agenda, which must address a composite of private and public interests.[2]

The harsh realities of economic limits must, from a practical point of view, frame the moral deliberations. Decisions about the claims of each element of the healthcare economy — the number of physicians trained, magnetic resonance imaging machines purchased, hospital beds opened, drugs prescribed — effect a massive and complex budget that juggles these components, and myriad others, to arrive at the composite of the healthcare system. But while budgetary selections and prioritisations are readily acknowledged, what we now face is a situation in which the rationing of medical services, the *open* process of choosing how resources are equitably allocated, is rarely debated. Those who advocate a more democratic discussion of how such choices are made argue that the present unequal distribution of health services is *de facto* partition, and if health policy about access is not freely debated, then decision-making is ad hoc, planning is encumbered, and inequalities arise.[3]

To discuss rationing from a moral perspective, one must take account of two looming philosophical problems. The more fundamental one, which orients this discussion, concerns how to place healthcare within an encompassing context of distributive justice.[4] The liberal perspective advocates fair equality of opportunity,[5] which, in the context of healthcare, means that preventing and treating disease and disability assumes its moral importance by maximising the opportunity of individuals to participate in the social, political, and economic life of their society. If one maintains that healthcare is a fundamental human right because of its central role in preserving such opportunity for all citizens, then the equitable distribution of medical resources becomes a political goal to maximise the "fair-equality-of-opportunity" principle.[6] The second philosophical problem, closely linked to the first, is the question of how individual rights are understood within a healthcare context? To address these two issues, I will comment on how the competing claims of individual autonomy and communal care might be regarded as complementary, and thus fundamentally interdependent.

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ABSTRACT

- Rationing, the *equitable* allocation of medical resources, is both an economic and moral challenge — economic, because the various components of healthcare must be budgeted; moral, because the prioritisation of these resources is a value-laden decision.
- The moral debate about rationing pits individual choice against communal interests.
- The advocacy of equitable distribution of healthcare resources originates in arguments for distributive justice and a revised version of individual autonomy.
- If autonomy is defined strictly in terms of atomistic individuality, then the social obligations and duties of persons are subordinated to their individual rights.
- Alternatively, when people are defined by their relationships, "relational autonomy" balances responsibilities against the claims of individual rights to maximise distributive justice.
- The concept of relational autonomy provides medicine with a philosophical basis for communal rationing of healthcare resources.

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A philosophical dissection

Rationing comes under the most fierce fire when its opponents claim that such control over distribution of medical goods and services (determined by the group) violates the principle of individual rights. This latter perspective maintains that people with more financial resources have the right to purchase better healthcare than poor people. To make restrictions designed for uniform and equal access (ie, rationing) is then regarded as an imposition of group utilitarianism against the private and privileged interests of the patient. In short, the debate about rationing pits the

rights of (rich) individuals against the equitable distribution of communal clinical resources. We should then characterise those individual rights, and to do that, we must define "individuals" who make claim to rights. In other words, how do we construe individual autonomy?[7,8]

"Autonomy" refers to the sense of self-governance coupled to a moral sense of responsibility for the choices made. These assertions, of and by themselves, are not particularly contested, but their interpretation is, depending on how the moral agent (the self) is defined. One view holds that the self resides independent of other relations, and thus the various meanings generally attached to autonomy reflect this sense of the person as atomistic, self-determined and self-supporting. The other view is that none of these criteria of autonomy precludes inter-dependence, and the assertion of radical individuality is a conceit that ignores the social context and social character of people.[9]

The social character of people radically challenges an individualistic construction of autonomy. Individuals clearly have multiple identities conferred by different social roles with different kinds of obligations and fulfilments. Correspondingly, the moral agency associated with each identity differs. To assume that a single autonomous identity supervenes and orders the others in all situations not only oversimplifies, but actually falsifies the character of selfhood. Radical individualism claims that agents are causally isolated from other agents (ie, independent of family and community relationships in which they participate). But "independent selves" are in fact highly integrated into myriad relationships and locked into determined behaviours as a result. Thus, a radically independent, autonomous person is at best an idealised portrait of a fictional character — part of an elaborate ideological cartoon of Western culture that celebrates self-reliance over relationship.

Opposed to this conceit of independence stands the social conception of identity. "Relational autonomy" emphasises how people are constituted by their social roles, and these various identities confer opportunities for choices as well as for responsibilities and duties.[9] From this perspective, freedom of choice is always determined within the context of the social and moral structures of the community. Healthcare is a particularly clear case of obligation.[10,11] Assuming a liberal stance, to correct for the contingencies of disease and disability, we owe assistance to each other (by the fair-equality-of-opportunity principle), but further, this obligation is a communal responsibility — the entire community is invested, and invests, in medicine — to maximise opportunity for all. On this view, commercial interests are subsidised by the public, and the public is thus justified in distributing resources equitably for the benefit of all citizens. Here, we come face to face with the moral conundrum of rationing.

A philosophical approach

Atomistic autonomy begins with an assumption of human separateness and celebrates freedom of choice as essential to individual well-being. Accordingly, deliberate rationing of community-held resources violates the free exercise of individual options, and thus denies the rights of patients. In contrast, the social ethic of care begins with an assumption of human connectedness. Its goal is the equitable distribution of goods, because common goods are held by the community, and these are distributed not by individual ability to obtain them, but on the basis of distributive justice.[4] Communal relationships are thus fundamental and must be protected. The first view understands freedom as separateness (where autonomy is historically best situated); the second is founded on obligation and connectedness (where autonomy is regarded as arising from relation with others). In short, these differing conceptions of the person, with their concomitant attitudes about rights, currently conflict. How can they be reconciled?

I suggest we look more closely at the concept of autonomy. Most people associate autonomy with individual rights. However, there is a complementary aspect of autonomy; namely, individual obligations to the community, within which those rights are both protected and bestowed. This social interpretation, as opposed to libertarian ones,[12] rests on an important distinction: There is no *autonomous self* or an *autonomous person* or *autonomous individual*, but rather *autonomy of reason*, the *autonomy of ethics*, the *autonomy of principles*, and the *autonomy of willing*.[13]

Autonomous individualism, associated with a liberated self, freed from political, religious, and social bonds, incorporates a distinct, but contested understanding of the person (as discussed above). Properly, autonomy (even in its more common individualistic interpretation) is "principled autonomy", not "individual autonomy". This means that people choose their moral actions according to universal principles of action. Hence, so-called "principled autonomy" is not something one *has*, nor is it equated with personal independence or self-expression. Rather, it is the self-legislated moral behaviour prescribed by principles that could be laws for all.[5] Accordingly, autonomy requires respect for the rights of others, and, moreover, a premium is placed on the cooperative nature of morality from which justice must be derived.

This perspective radically recasts widespread beliefs about individuality and rights. It shifts the burden of moral action on meeting obligations to others, as opposed to asserting self-defined liberties. A relational understanding of autonomy thus regards the selfish pursuit of individual goals irrespective of the common good as fundamentally immoral. On this interpretation, autonomy must be reformulated into a balanced relationship between the needs and rights of the individual with due consideration of the interests of the group.

When these arguments are applied to healthcare, the moral debate is keenly focused. If the atomistic, individualistic understanding of the self is promoted, then rationing is regarded as an imposition on the rights of the individual. Medical resources, presumably above a bare minimum, are for those who can purchase them, and the right to do so cannot be restricted. If, in contrast, the citizen is regarded as a complex balance of private and communal identifications, then healthcare rationing, which imposes strictures on resources in answer to the needs of all members of the community, is understood as an obligation paid by individuals to their social group. In short, if healthcare is regarded as

a *communal* resource and responsibility, the group's interests prevail over the individual choices that wealth might confer.

Plainly, my position is that healthcare, like justice, should be distributed equitably, because fair access to commonly held resources optimally permits *all* individuals to reach their full social and personal potential. This is a precept of distributive justice, and, accordingly, autonomy is placed in a broad social context to balance individual rights against inequality and injustice. Rationing then assumes its moral force from a dual allegiance to notions of communal responsibilities of individuals (relational autonomy) and a social philosophy advocating equitable sharing of communal healthcare resources (distributive justice).

But why should the equitable distribution of society's collective healthcare needs be favoured against the claims of individual choice, which, in Australia and the United States, are often determined by wealth? In short, why should *physicians* adopt the orientation advocated here? The answer is found within the ethics of medicine itself.[14]

A medical ethics perspective

A counterargument to my support of rationing is over the terms of distributive justice. One might, I suppose, argue against equitable distribution of healthcare, but I believe such a position originates from outside medicine's own moral universe. In the United States (albeit less so in Australia) healthcare is largely a commodity, competitively purchased and run by market forces. Because of economic stratification, the wealthy few have better care than the greater number of the poor. (Putting aside the enormous influence of socioeconomic disparities on health, the moral question of healthcare inequality loses none of its force.) This is a political and social reality in our societies, which carries its own moral justifications. But socioeconomic inequalities have generated a moral quandary for doctors. Indeed, the inequality of healthcare is contradictory to the physician's deepest moral commitment — the care of all by those who (at least ethically) know no hierarchies of human worth. While each person is endowed with a unique biological constitution and social identity, and their healthcare needs correspondingly differ, physicians make no *moral* judgement on those differences — medical ethics demands non-discriminatory care.

So we are left with an ethical tension: physicians should take no moral account of human difference — rich and poor, old and young, criminal and priest have equal claims to care. However, the reality of scarce resources demands prioritisation. Rationing squarely addresses the social and economic reality that choices must be made, and it does so by providing a more open process by which equalised distribution of clinical services becomes a goal. This process depends on evidence of clinical efficacy, a scientific assessment, *and* deliberate, often painful, allocation of community resources, which invoke value judgements (eg, investment in preventive medicine as opposed to end-of-life interventions).

While stratification continues (because of limited resources), rationing effectively establishes rules of access applicable to all. Just as judges follow the law to adjudicate, so physicians might practise knowing that communal guidelines assure the just distribution of medical resources.

No doubt, rationing is a difficult moral problem because it requires judgements that potentially conflict with personal values. I would not argue for moral consistency and potentially write off those conservatives who are committed to individual rights and freedoms at the possible expense of communitarian demands. Instead, I suggest that a doctor might still be a conservative concerning personal, and even certain social matters, and at the same time endorse rationing because of a commitment to the medical profession. Medicine's professional ethic demands that all who might profit from care be cared for. As physicians, we have entered into a social contract that accepts the equal worth of every life, independent of economic or social stratification. That inequalities exist and will continue to exist is not at issue. The moral position advocated here supports the *attempt* to attain equality within a universe of limited choices. On this view, rationing takes on a moral imperative as part of medicine's general ethics.

Conclusion

I have provided a philosophical justification for rationing of healthcare resources, but that is not enough. The boundaries of the clinic are porous and determined by the supporting social and economic forces well beyond its walls. Politics are not usually included as part of medical practice, but perhaps when the moral implications of social injustices are understood as interfering with an ethical medicine, more physician activists will be born who will elect to split their efforts between the hospital and the political arena. For them, responsibility for their patients' medical welfare is comprehensive, and abiding.

Competing interests

None identified.

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