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care priorities**

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Abstract

This paper discusses the moral relevance of accounting for various personal characteristics when prioritising between groups of patients. After a review of the results from empirical studies, we discuss the ethical reasons which might explain – and justify – the views expressed in these studies. The paper develops a general framework based upon the *causes* of ill health and the *consequences* of treatment. It then turns to the question of the extent to which a personal characteristic – and the eventual underlying ethical justification of its relevance – could have any relationships to these *causes* and *consequences*. We attempt to disentangle those characteristics that may reflect a potentially relevant justification from those which violate widely accepted principles of social justice.

Introduction

Deciding the principles on which publicly funded health care should be distributed has come to be a crucial health policy issue in most countries. Much of economics is based on the efficiency principle of maximising health. Partly as a critique of this principle, there has been increasing interest in alternative – or supplementary – dimensions with explicitly ethical origins (e.g. Williams, 1988). A number of characteristics of people and their illnesses have been investigated to determine to what extent the population – as represented by responses to various surveys – wish to account for such characteristics when setting health care priorities (e.g. Charny, Lewis & Farrow, 1989). For example, should people be held responsible for own health related behaviour, or, should their importance to other people’s well-being count when allocating scarce health care resources? We shall refer to various characteristics of these sorts as *personal*: these cover behavioural characteristics that may relate to the cause of the illness, a person’s relation to others, and characteristics of a person’s self or very identity.

The question, then, is which characteristics are potentially policy relevant. An implicit assumption in the empirical studies has been that, when the majority of the population votes for the inclusion of a personal characteristic then it should be taken into consideration in the decision making process. However, it is not necessarily true that policy makers should always adopt the result of a majority vote, because the public may express ethically unacceptable preferences, such as discrimination on the basis of race. Therefore, we would require that a personal characteristic is defensible in terms of a moral argument before it is potentially policy relevant (Richardson, 2002). This view is consistent with the argument that we should consider ‘laundered preferences’, i.e. preferences that are screened by ethical argument (Broome, 1991). The chosen approach of this paper is to tie the ethical reasoning to the causes of ill health and the consequences of treatment.

The aim of this paper is to discuss the moral relevance of various personal characteristics when prioritising between groups of patients. We shall do this by providing a comprehensive overview of the matter and articulating a preliminary ethical analysis of the issue. By way of background, the next section presents the results from a review of relevant empirical studies. Section three inquires into the ethical reasons which might explain – and justify – the views expressed in these surveys. Section four develops a general framework based upon the *causes* of ill health and the *consequences* of treatment. It explores the extent to which a personal characteristic – and the eventual underlying ethical justification of its relevance – could have any relationship to these *causes* and *consequences*. We will try to disentangle characteristics that may be defended by legitimate ethical argument from those which merely reflect prejudices.

Empirical literature on people’s views on personal characteristics

The concept of personal characteristic in this paper will *not* include attributes related to those ‘health streams’ that are central in the discussion of efficiency or distributive justice in health; namely, a person’s expected health *gains* from treatment, the *severity of her illness*, or her *age*.¹ While many empirical studies of personal characteristics have included age, we consider age to be related to a point in each person’s lifetime as distinct from characteristics which separate one individual from another. The types of characteristics dealt with in this paper are of three kinds: 1) those that refer to a person’s *relations to other people* in society (e.g. having children); 2) those that place the person *in a causal relationship with the illness*, i.e. the extent to which a particular illness might have been influenced by their own actions (e.g. smoking), and finally; 3) those that are ‘embodied’ in a *person’s self* physically, intellectually or attitudinally (e.g. gender).

Surveys that have investigated people's views on the extents to which the identified characteristics should have any role in health care priority setting have been identified by Dolan & Shaw (2001). Their search was carried out using various databases, including EconLit, Medline, Sociological Abstracts and PsycLIT. The key terms used were health, efficiency, equity, trade-off, justice and fairness. Some of these surveys investigated general principles, while others consider the issue within the context of a particular case, e.g. liver transplants. The questions presented to respondents were whether a particular attribute should be taken into account when prioritising scarce health care. There are vast methodological differences between these studies, and the quality of the empirical evidence presented is variable. However, the purpose of this part of the paper is not to present a critical review of this literature, but rather to identify which types of personal characteristics that have been investigated empirically.

The first column of Table 1 lists the personal characteristics that were identified in these studies. The second column gives the sign of the effect of the characteristic, i.e. whether it was thought to justify higher or lower priority. The third column gives the percentages of respondents in each study that assigned a higher or lower priority. More than one number in a row indicates a references to more than one study, the order of which follows the order of references given in the first column. (Summary information on sample size, population surveyed and nature of question for each study is provided in the appendix).

Table 1 about here

Table 1 suggests that most of the characteristics that have been investigated concern a personal relationship with other people, an economic relationship with the wider community, or some aspect of a 'self-inflicted' disease. Due to the very different methodological approaches regarding sample sizes, respondent groups and descriptions of the characteristic, one must be cautious in comparing the percentage support across studies. However, the picture that emerges is that survey respondents have been *most* willing to favour parents of small children, and to discriminate against substance users. They appear to be *least* willing to discriminate on the basis of characteristics related to a person's self, i.e. gender, race and sexual orientation.

Apart from the result that showed 60% support for giving non-smokers higher priority, none of the remaining characteristics gained majority support, i.e. they were consistent with a policy of non discrimination on the basis personal characteristics. Still, sufficiently large minorities support the use of some of the characteristics in Table 1 to warrant an inquiry into the possible reasons behind such views.

Seeking ethical justifications for the empirical findings

Characteristics that deal with the importance of the person's *relations to other people* in society could either be considered *prospectively* by judging future consequences of treatment, or *retrospectively* in terms of reward (or punishment) for past actions. This distinction is important because it may call into play different ethical arguments. Utilitarian and egalitarian arguments are consequentialist and thus have a natural role in prospective reasoning, while judgements about deserving or punishable behaviour more likely reflects retrospective reasoning that is often based in arguments that are ultimately neither utilitarian nor egalitarian.

Utilitarian reasons

According to the utilitarian ‘greatest happiness principle’, the change in the utilities of all affected parties are to be included when assessing the goodness of a programme (see e.g. Mackie, 1977; Sen & Williams, 1994). The more happiness generated, the stronger the claims are for health care.

It is possible to distinguish between *pecuniary* and *non-pecuniary* utility, implying a corresponding division between what might be termed ‘*pecuniary* utilitarianism’ as opposed to ‘*non-pecuniary* utilitarianism’. The amount of happiness among others as generated through caring and personal interaction can be referred to as *non-pecuniary* utility. This is reflected in peoples’ preferences for giving priority to patients who return to care for their elderly relatives, or patients who return to care for their dependent children.

In contrast, *pecuniary* utility refers to the happiness generated by what a treated patient is able to produce. The more valued one’s health-dependent skills, or the more one contributes to society when one is healthy, the higher total *pecuniary* utility the person generates. Together, the magnitude of the generated *pecuniary* and *non-pecuniary* utility comprise the concept of ‘social worth’. Such utilitarian reasons for regarding some people as having greater claim on health care have recently been suggested by Edgar, Salek, Shickle & Cohen (1998): “It would in principle, be possible to discriminate between people according to their skills and abilities, with those whose talents are widely recognised and appreciated being regarded as more socially valuable and so receiving preferential treatment”.

Egalitarian reasons

While many types of discrimination ‘would in principle be possible’ on utilitarian grounds, they may be inequitable as judged by egalitarian principles. Egalitarianism advocates equal shares across individuals of the entity that is to be distributed (see e.g. Elster, 1992; Le Grand 1996; Sen, 1992). *General* egalitarianism favours equal distributions of utility or well-being; a more *specific* egalitarianism focuses, in this case, on health care or health. A preference for giving priority to people with a particular personal characteristic might be justified by the former case, that is, by compensation for disadvantages in other walks of life, such as poverty or low socio-economic status. Conversely, giving *lower* priority to rich or important people could be justified in the context of a national health scheme on the grounds that such people are more fortunate in other respects, but also on the grounds that such groups are financially capable of paying for themselves. Hence, such priorities might reflect preferences which are based upon the secondary objective of reducing inequalities in life-time well-being across different socio-economic groups.

Desert and merit

According to desert and merit reasoning past actions would impact upon an individual’s entitlement to health care; honourable social actions make people more deserving later in life for health care, and criminal or other dishonourable activities may reduce one’s entitlements. The empirical findings referred to above suggest only weak support for such *retrospective* concerns (as indicated by the support for and against the characteristics ‘contributed a lot to the community’, and ‘prisoners with criminal record’). The distinction between past actions which were *good or bad* implies that society might look back in anger or gratitude when prioritising resources between individuals. This implies that the health service can impose additional rewards or punishment – like an omnipotent Supreme Court. However, a more convincing ethical argument to us, is that once atonement has been made for past *bad*

actions through the legal system, criminals become free citizens who thereby also regain their entitlements to public services such as health care.

Past *good* actions carry – by definition – a connotation of altruism or performance of duty to them, such as ‘contributed a lot’ or ‘honourable’. While the argument may, at first, appear to be unusual, the principle of rewarding at least some past actions has been widely accepted and implemented. Many countries have established special facilities for the treatment of war veterans, and such ‘veteran health services’ have been extended to include all health care. However, in a different context, it is interesting to note that rewarding social goodness might, in fact, undermine the motivation for good actions. Extrinsic rewards may reduce intrinsic motives. This may be illustrated in the market for blood where payment has allegedly resulted in a *reduction* in supply, because the goodness in the act of donation is devalued (Titmuss, 1970).

In the same way as a distinction can be drawn between the impacts on others’ *health* and others’ *wealth* when looking prospectively, there is an analogous distinction when looking retrospectively at behaviour: Past actions could have impacted upon other peoples’ health or upon other people’s wealth. An example of the former is a person who has rescued the life of a fellow citizen, and has harmed himself as a direct consequence of that venture. In this case, we would find the life-saver to have increased entitlements to health care, because his need for health care is directly related to the past action. As such, it represents a kind of desert that differs from an idea of being a generally more deserving citizen due to past good actions that would be *unrelated* to the current health care need, e.g. having been a philanthropist. However, rather than suggesting that efforts directed to improving other people’s health are in general more virtuous than are efforts directed to improving deprived people’s general well-being, there appears to be two more important ethical concerns. They are, first; whether a person’s need for health care is a direct result of her virtuous actions, and second; whether the person’s efforts have already been rewarded (i.e. voluntary efforts are more meritorious than paid ones).

Exogenous and endogenous causes

The second general category of characteristics discussed in this paper concerns the person *in relation to the illness*. The emphasis here is on the extent to which the causes of the illness are exogenous to the person, or whether the causes could be explained by a person’s own (unhealthy or risky) behaviour. According to Edgar, Salek, Shickle & Cohen (1998): “It is possible to argue that QALY gains from treating ill-health which is brought about as a result of individual’s own behaviour (smoking, drinking, engaging in dangerous sports, etc) should be of lower value than those from treating ill-health for whom the victim was blameless. By the same token, more weight may be given to health benefits provided to those whose health has suffered through factors outside their control such as deprivation or unemployment”. Again, while these authors hold that ‘it is possible to argue’, they offer no ethical *reasons* in support of their assertions. The moral reasons we suggest are based on a distinction between exogenous and endogenous causes of ill-health.

The preferences for equity might refer to actions that reduce those inequalities in health that are the result of factors that lie *beyond* people’s own control (see e.g. Le Grand, 1996). People with inherited diseases may experience less health, and so also would people who are deprived because of the physical or social environment. Since society is *not* indifferent to the causes of ill health, we would feel more obliged to compensate those groups whose ill health have *exogenous causes*. Society may feel particularly obliged to compensate for deprivation when ill health could have been *avoided* under different social and environmental policies.

Misfortune, or ‘blameless’ suffering, is the flip-side of blameworthiness. The fact that some events hit seemingly at random in every social class make people realise that we are all fragile – ‘it might happen to one of us (not only one of them)’. Some have been unlucky in the biological lottery to be born with an inherited disease, and some have been the victim of an identified inflictor, e.g. being hit by a car on a pavement. Under such – by nature or by faith – exogenous causes, there appears to be a strong will to compensate the unlucky ones.

Endogenous causes are pervasive, but ill-health would rarely be entirely attributable to a person’s own actions. Even with ‘life-style diseases’ most of the variation in who contracts a disease is unexplained. Thus, one cannot take population based epidemiological determinants and hold individuals personally responsible for their illness. Nevertheless, Table 1 suggest that perceptions of blame are quite common, e.g. ‘self-inflicted ill health’ and ‘contribute to their own illness’.

There are two quite different arguments for punishing those whose unhealthy preferences are manifested in an unhealthy life-style, and for whom there is a higher probability that their current ill-health has been caused by their chosen life-style. First, there is the simple economic burden argument that ‘smokers should pay their way’. However, if smokers pay more than their excess health care costs through tobacco taxes, and adjusting for differences in pension pay-outs, this argument is not valid (Menzel, 1990). The second argument has more of a moralistic overtone and is based on the idea that we have a duty to live healthily; risk aversion becomes a higher moral order. Those who disobey would be punished by having a diminished claim on health care.ⁱⁱ

Returning to our three types of personal characteristics, it seems difficult to find arguments that are based on ethical reasoning in support of the listed characteristics that are ‘embodied’ in a *person’s self*. Rather, these characteristics – which happen to be the least explored in the literature and yield the lowest relative supports – are associated with various types of prejudice; such as sexism, homophobia, racism. Such preferences can of course be simply ‘laundered’ (Broome, 1991). However, this difficult exercise can be avoided in favour of a more analytical solution, as it turns out that personal characteristics embodied in a person’s self fall outside the framework developed below. Within this general framework we investigate the extent to which a personal characteristic – and the eventual underlying ethical justification of its relevance – could have any relationship to the *causes* of ill health or the *consequences* of treatment.

Causes of ill health and consequences of treatment

The starting point: outcomes and severity

The discussion above suggests that a person’s claims on health care could be affected by personal characteristics in addition to her health care needs. To progress this argument, a clarification of the concept of *need* is required (see e.g. Olsen, 1997). If ‘need’ is interpreted as ‘capacity to benefit’, then the only relevant consideration is the impact of health care on health gains. There is a causal functional relationship between health care and expected health outcomes. This argument is illustrated in Figure 1, in which the solid *causation arrow* from health care to health outcomes determines the dashed *claim arrow* ① from health outcomes to health care. An alternative interpretation of ‘need’ is ‘need as ill health’, i.e. that a patient’s severity (or ‘no-treatment profile’) is important in society’s judgements of her entitlement to health care. There is, however, no causation arrow between ill health and health care, but a *claim arrow* ② which reflects a societal preference for prioritising the most severely ill patients.

Figure 1 about here

The concept of a *claim* refers to ‘a duty owed to the candidate herself that she should have [the good]’ (Broome, 1991). Alternatively, claims could be of a more communitarian nature in that they ‘fall to the community to exercise duty over’, and ‘claims do not have to be recognised by the individual who has the claims’ (Mooney, 1998). However, claims appear to bear some resemblance to ‘need’, since the latter concept carries ‘significant ethical overtones; its allegation asserts an obligation on others’ (Evans, 1984). In the following, we shall use the word *claim* to express the extent to which a personal characteristic represents a legitimate reason for society having a higher or lower obligation to that particular person (or group of persons) when deciding on priorities in health care.

Our starting point for the conceptual framework spelled out below is that a person’s claims for health care depends on *needs*, i.e. her individual expected health *outcomes* and/or the *severity* of her current ill health. In the context of cost-effectiveness analyses, what matters is the impacts of health care on the patient’s own health outcomes – i.e. ‘need as capacity to benefit’. More recently, methodological contributions have been made in attempting to weight the importance of severity with that of gains (see e.g. Nord, 1993). Thus, what matters is illustrated by the two claim arrows, ① and ②, in Figure 1. This model will now be put within a wider context, which suggests that additional claims – beyond the aforementioned conceptions of needs – depend crucially on the causes of ill health and the wider consequences of an individual’s improved health.

The determinants of (ill) health

The framework for the determinants of ill health, as depicted in Figure 2, is influenced by the models by Evans & Stoddart (1990) that consider genetic endowment, the physical environment and the social environment, to be the three determining factors which produce ‘host’ responses in the individual. These responses, then, reflect ‘social conditioning’ as well as more biological reactions to the environment. The variable ‘genetics’ refers to natural variations in human biology and explains inherited diseases. This is analytically separated from the whole range of environment-factors; be it one’s physical environment including working conditions and pollution, and the social environment including cultural norms and one’s position in the social hierarchy (see also Evans, Barer & Marmor, 1994).

However, a model that explains revealed ‘lifestyle’ purely in terms of individual responses to the environment becomes rather deterministic. At the other extreme are models that consider lifestyle as revealing private sovereign choices. A more fruitful, intermediate, approach is to consider ‘lifestyle’ to be determined by factors over which individuals have *different degrees of discretion*, which vary from constraints upon the life one can possibly live to factors over which one might have complete discretion. We have therefore supplemented the picture by adding ‘preferences’ as a determinant to reflect variations in individual choices – or ‘tastes’. A particular preference *per se* is not unhealthy. It is when a preference is revealed through behaviour that it may become healthy or unhealthy. Thus, a health related lifestyle depends upon a combination of individual *responses* to the environment, and individual *choices* based on sovereign preferences. While there are sharp moral and ideological disagreements over *which* actions a person should be held responsible for (i.e. whether a given action is a response or a choice), our suggestion that individuals have different *degrees* of autonomy when making lifestyle choices should be less controversial.

The model illustrated in Figure 2, sets out three initial determinants of (ill) health; i) genetics, ii) the environment (physical and social), and iii) preferences. In reality, they are not

completely independent of each other, but for simplification the possible links between each of them are not included in the figure (e.g. there could be an arrow from preferences to social environment to reflect the view that people to some extent choose their own environment). Among these three determinants, i) and ii) are – in principle – directly observable, while iii) is not. The way preferences become observable is in their revealed lifestyle, but again, this lifestyle is influenced by individual responses to genetics and the environment. While *lifestyle* could refer to any sort of behaviour (be it transvestism or smoking), in this context we narrow it to those *styles* that are known to have an effect on *health*, such as diet, exercise and substance use.

Figure 2 about here

Our emphasis on identifying *health related lifestyle* within this map of causation is justified on the grounds that this variable is often associated with self-inflicted diseases, for which, some would argue, individuals should be held responsible. However, the model suggests that a ‘lifestyle-disease’ is not just self-inflicted, but rather caused by a mental or biological response to the environment in which the person lives. Hence, it appears that an unhealthy lifestyle which follows from unhealthy individual tastes (discretion) is more blameworthy than were the same lifestyle to be explained as a part of the culture (constraint) within which the person lives.

Having described this map of causation, the question then is which of these determinants of ill health might be legitimate grounds for assigning a greater or lesser claim upon health care. It appears that society considers people who have suffered from *misfortune by nature* (‘inherited disease’) to have a greater claim, as illustrated by the claim arrow ③. The claim arrow ④ indicates compensation for various kinds of exogenous environmental causes, most often related to social *deprivations* (‘deprived in other ways’, ‘lower socio-economic status’, ‘poor’, ‘unemployed’).

The claim arrow ⑤ suggests a view that people should be held *responsible* for their own actions. To the extent that people – based on their preferences – have chosen a particular unhealthy lifestyle (‘self-inflicted ill health’), they are then to be punished by having a lesser claim on health care. These views appear to reflect a perception that individuals have considerable discretion with respect to these factors; i.e. that unhealthy behaviour is something people freely choose, not something that they respond to automatically as a result of an unhealthy social environment.

The consequences of treatment

We have distinguished between two types of consequences or effects upon other people resulting from an individual’s health improvement. The first deals with the emotional impact, identified in Table 1 as the effect of *health* related wellbeing for others (‘have children’, ‘caring for elderly relatives’, ‘married’). It follows that the larger the impact of this kind, the stronger will be the claim on health care; (arrow ⑥ in Figure 2). The second type of consequences deals with the economic contributions to society (‘breadwinner’, ‘employed people’), something which impacts upon other peoples’ *wealth* related wellbeing. Such impacts are termed ‘indirect benefits’ or ‘production gains’ in the economic evaluation literature.

Returning to Table 1, people seem to believe that emotional effects represent a more legitimate basis for claims than the economic effects. This could be explained by different degrees of replaceability. With regard to the emotional impact one has on friends and family,

an individual is largely irreplaceable. However, our economic contribution may be replaceable, and the burden of any shortfall can be shared.

Discussion and conclusion

Taking account of differences in personal characteristics when setting health care priorities is indeed problematic, both conceptually and practically. Traditional economics avoids the moral problem by sanctifying the principle of consumer sovereignty in which ‘preferences are inviolate’, whatever characteristics people want to count should count. No attempt is made to distinguish between prejudices and ethically defensible arguments. Among ethicists, the moral aspects of concepts like ‘desert’, ‘responsibility’ and ‘social worth’ are discussed, but are often not related to the contexts in which these concepts become relevant for setting health care priorities.

In this paper, we have tried to identify the personal characteristics which have *potential* moral relevance and to separate these from characteristics which do not. We have suggested that a characteristic is potentially relevant if it is related to a *cause* of ill health or the *consequence* of treatment. In addition we have independently considered the relevance of different characteristics that have been studied empirically (Table 1). In Table 2 these two strands of the paper are brought together. The framework is, in effect, ‘cross checked’ using the previous discussion.

The first three columns in Table 2 reflect consequentialism. The *utilitarian* arguments discussed in this paper have been subdivided into those described as pecuniary and those described as non-pecuniary. We have suggested that people may place greater importance upon the latter than the former. The egalitarian argument involves an attempt to offset inequalities in health or wellbeing. The last two columns reflect non-consequentialist arguments. There are two reasons for retrospection upon past actions; *desert (and blame)* refer to whether or not a person’s interactions with other people have been meritorious or blameworthy, and; *responsibility*, which refers to the extent to which the person can be held responsible for her ill health through past unhealthy behaviour. When we suggest that a personal characteristic has relevance for an ethical argument, + / – signs are used. The former symbol indicates that the characteristic would give *more* weight, while the latter indicates *less* weight. Blank cells suggest that there is no apparent relevance of the ethical reason for the personal characteristic under consideration.

Table 2 about here

The first three characteristics in Table 2 have relevance from a non-pecuniary utilitarian perspective (+ in the second column). Characteristics related to a person’s economic importance (rare skills, employed, rich) can all be supported on the basis of ‘pecuniary utilitarianism’, but it would imply inequitable distribution of health gains, as well as unequal access to health care (– in the third column). Giving priority to unemployed or poor people is usually justified on the ground that it would reduce inequalities in well-being (+ in the third column).

The subsequent personal characteristics of ‘past contribution’ and ‘criminal record’ fell out of our framework illustrated in Figure 2, as they have nothing to do with the cause of ill health, nor with the consequence of cure. However, such characteristics become relevant on the basis of desert and merit. Based on this view, one would assign higher priority to those with socially approved past actions (contributions) and lower priority to disapproved past

actions (criminal). Our counter arguments are based on social justice. It seems to us that only when current need for health care is a direct consequence of an activity intended to improve the wellbeing of fellow citizens, is the idea of desert morally relevant. As for past criminal behaviour we have suggested that one's entitlements to health care can be reduced only when atonement to society more generally has not yet been made. Otherwise, good and bad past actions should be 'cleared' in the relevant spheres and sectors of the society. It is not for the health service to assign limited or increased entitlements to its services depending on differences in past actions *unrelated* to a person's current health.

The second set of personal characteristics concern the causal relations between a person's behaviour and the illness. The relevance of this is justified primarily on the grounds that people have a responsibility to live a healthy life.ⁱⁱⁱ The most hotly debated characteristics discussed in this paper is whether 'self-inflicted ill health' should reduce a person's claims upon health care (– in the fifth column). The flip side – whether those who have 'taken care of own health' and thereby increased their claims – depends upon the same ethical argument, namely, that we have a duty to live a healthy life and avoid unnecessary use of collective resources.

There are two broad counter arguments. First, a strong socio-economic gradient exists which explains a large part of the variations in individual health related lifestyle preferences [see for example Marmot & Wilkinson (eds), 1999]. Thus, giving higher priority to those who lead healthy lives advantages the already socially fortunate. Conversely, giving less priority after unhealthy behaviour implies the 'victim-blaming' of people living in socially unfortunate environments (column 3) and such a policy might accentuate social inequalities. The second argument against the relevance of lifestyle is the view that it is the state one is in – not the cause of the disease – that is of relevance. With respect to ill health induced by 'illegal drug', there might be two ethical reasons for assigning lower weights: first, we become less deserving when involved in an illegal activity, and; second, such substances are more likely to be the cause of ill health (irresponsibility). However, the persuasive counter argument which applies more generally is that the health service has been established to treat people in need, not to pass a verdict on people whose behaviour is unacceptable or illegal.

It is hard to find any ethical reason which might justify the moral relevance of the third kind of personal characteristics, namely, those directly concerning a person's self. They all violate important principles of human tolerance. A crucial issue here is to what extent discrimination against – or in favour of – specific groups of people represents significant harm to *other* people. Furthermore, one may disapprove of the inclusion of a characteristic which would conflict with the widely shared community values that are often signified in the statement of health policy objectives, such as access independently of gender, sexual orientation, race, etc..

We have not sought to consider the practical implications of various moral arguments in this paper. It may, of course, be impractical to implement policies suggested by some of the ethical arguments. The framework in Figure 2 might still assist when determining the extent to which more or less health care funding should be allocated to certain programmes. For example more could be allocated to handicapped or deprived groups for compensatory reasons (arrows ③ and ④), or more resources could be spent on changing the environmental determinants of unhealthy behaviour. If aspects of lifestyle over which people have significant personal discretion are considered to be ethically important (arrow ⑤, e.g. diet, exercise, smoking), then information campaigns and the price mechanism could be used to alter individual choices. Some countries have already implemented programmes by which higher priority for health care depends upon 'social worth'. For example, in Norway, patients who can return to work earlier may in some instances receive preferential treatment (arrow ⑦). Prima facie this practice seems to contradict the views that differences in economic

contributions are irrelevant, while differences in social and personal impacts are more relevant (arrow ⑥).

More generally, there has been too little empirical research concerning peoples' social preferences. There has been even less research to distinguish ethically based considerations from prejudices. Constructive additional research should focus upon an understanding of the motivation behind social preferences. This will require greater emphasis upon qualitative research designed to probe people's beliefs and their ethical bases. In this paper, we have attempted to present an overview which might be considered as a suggested framework for future ethical debate.

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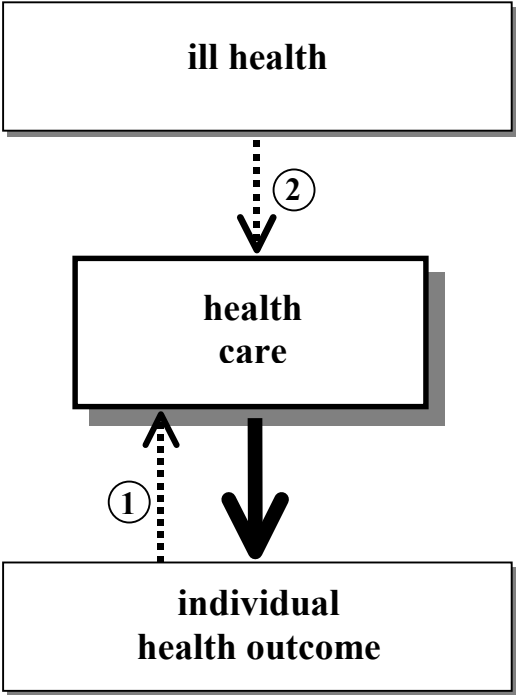
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Table 1: Personal characteristic that have been studied empirically

	Priority sign	% support
A person's relations to others		
single vs married (1)	strong for latter	
married (2)	no priority	
have children (2, 3, 4, 5)	higher	20%, 33%, 16%, 47%
caring for elderly relatives (4, 5)	higher	15%, 45%
'breadwinner of the household' (4)	higher	3%
unemployed (2, 6)	higher	3%, n.a.
unemployed vs employed (1)	weak for latter	
unskilled vs director (1)	equal split	
lorry driver vs teacher (1)	weak for latter	
important (to the community) (2)	lower	5%
employed people (5)	higher	27%
rich (2)	lower	23%
poor (2)	higher	10%
'lower socio-economic status' (8)	higher	44%
deprived in other ways (4)	higher	4%
contributed a lot to the community (2, 4, 7)	higher	2%, 5%, n.a.
prisoner with criminal record (6)	lower	n.a.
A person's relation to (the cause of) the illness		
'contribute to their own illness' (9)	lower	42%
'have taken care of their own health' (4)	higher	30%
'self-inflicted ill health' (10)	n.a.	
smoker vs non smoker (1)	strong for latter	
smokers (2, 12)	lower	32%, 39%
non-smokers (3)	higher	60%
unhealthy diet (2)	lower	12%
diet vs inherited disease (1)	latter	
high vs low alcohol (1)	strong for latter	
high alcohol (2, 6, 11)	lower	35%, n.a., n.a.
illegal drug (2, 6)	lower	40%, n.a.
rarely exercise (2)	lower	20%
A person's self		
man vs woman (1)	weak for latter	
men (2)	higher	3%
women (2)	higher	3%
homosexual (2)	lower	10%
race (2)	no priority	

(1) Charny, Lewis & Farrow (1989); (2) Dolan, Cookson & Ferguson (1999); (3) Nord, Richardson, Street, Kuhse & Singer (1995); (4) Williams (1988); (5) Olsen & Richardson (1998); (6) Neuberger, Adams, MacMaster, Maidment & Speed (1998); (7) Skitka & Tetlock (1992); (8) Mooney, Jan & Wiseman (1995); (9) Bowling (1996); (10) Edwards, Boland, Wilkinson, Cohen & Williams (1999); (11) Ratcliffe (2000); (12) Jowell, Curtice, Park, Brook & Thomson (1996).

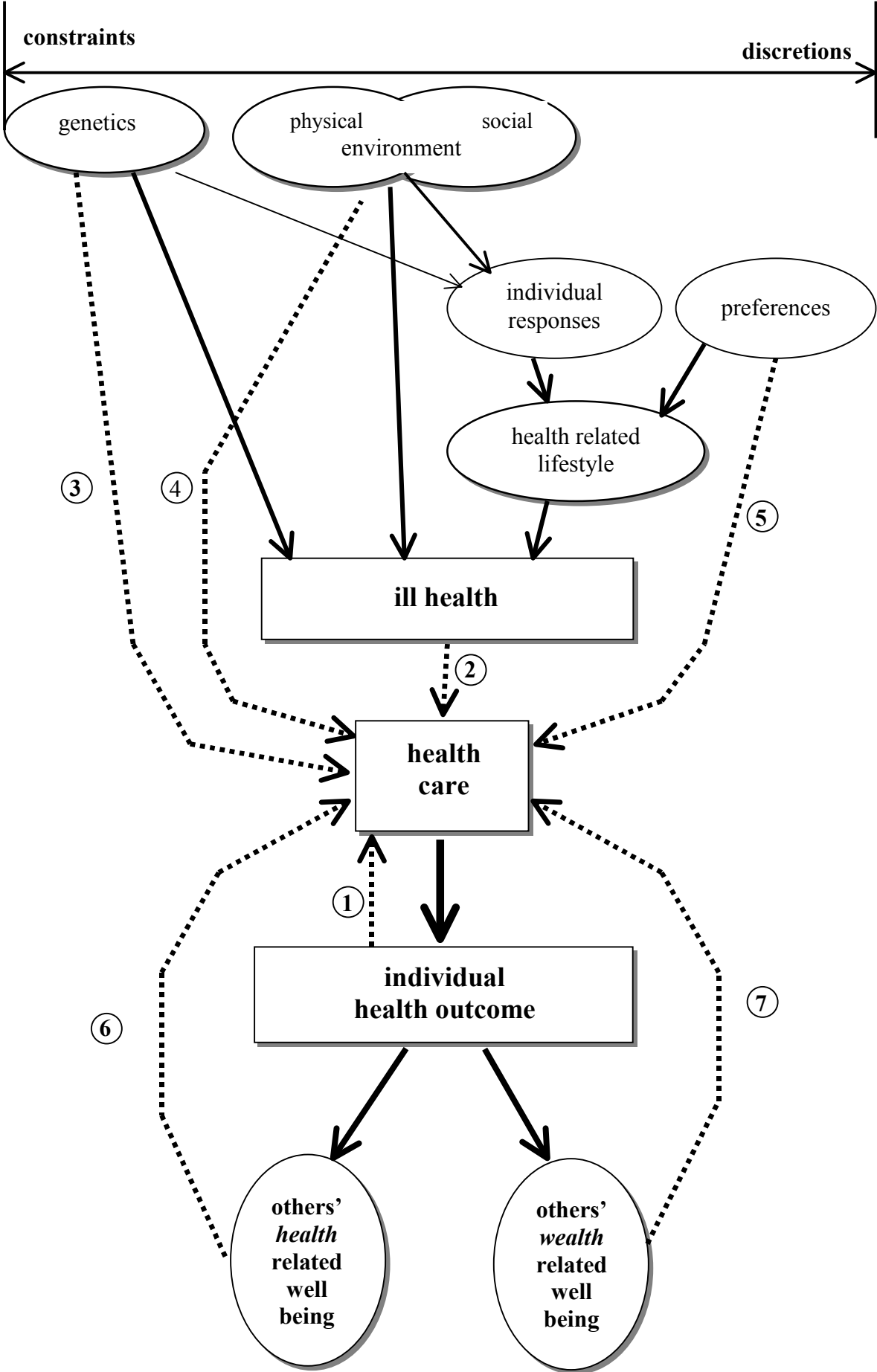
Figure 1: 'Need as ill-health' and 'need as capacity to benefit'



Footnote to Figure 1:

The solid arrow illustrates a *causation*. The dashed arrows illustrate *claims* for health care.

Figure 2: A framework of causes and consequences



Footnote to Figure 2:

The solid arrows illustrates a *causation* or an effect. The dashed arrows illustrate *claims* for health care, in which the circled numbers refer to:

- 1 – outcome
- 2 – severity
- 3 – compensation for misfortune by nature
- 4 – compensation for deprivation
- 5 – punishment (reward) for unhealthy (healthy) choices
- 6 – ‘non-pecuniary utilitarianism’
- 7 – ‘pecuniary utilitarianism’

Table 2: The relevance/irrelevance of personal characteristic

	Ethical reasons				
	Utilitarian		Egalitarian	Past actions	
	Pecun- -iary	Non- pecun- iary		Desert re others	Respons- ibility re illness
A person's relations to others					
married		+			
have children		+			
caring for elderly relatives		+			
rare skills, employed, rich	+		-		
unemployed, poor			+		
past contributions				+	
criminal record				-	
A person's relation to the illness					
inherited disease			+		
'taken care of own health'; non-smokers					+
'self-inflicted ill health'; smokers, rarely exercise, unhealthy diet, high alcohol					-
illegal drug				-	-
A person's self					
gender					
sexual orientation					
race					

Appendix

Summary information on the empirical studies reported in Table 1

Authors	Sample size	Population surveyed	Nature of question
(1) Charny et al, 1989	719	General public (UK)	Pairwise
(2) Dolan et al, 1999	60	General public (UK)	Focus group discussions
(3) Nord et al, 1995	551	General public (Aus)	Favour one group <i>or</i> equal
(4) Williams, 1988	81	Health employees (UK)	Favour one group <i>or</i> equal
(5) Olsen & Richardson, 1998	981	General public (Aus)	Favour one group <i>or</i> equal
(6) Neuberger et al, 1998	1,300	Gen pub & health empl (UK)	Selection from case histories
(7) Skitka & Tetlock, 1992	198	Students (US)	Alternative principles
(8) Mooney et al, 1995	283	Health employees (Aus)	Ordinal, pairwise
(9) Bowling, 1996	2,005	General public (UK)	Likert scale
(10) Edwards et al, 1999	2,270	Gen pub & health empl (UK)	Various
(11) Ratcliffe, 2000	303	University employees (UK)	Conjoint, pairwise
(12) Jowell et al, 1996	3,085	General public (UK)	Ordinal, pairwise

ⁱ For discussions of these characteristics, see e.g Dolan & Olsen (2001), Nord (1995), Williams (1997).

ⁱⁱ See the concept of 'healthism' in Skrabanek (1994).

ⁱⁱⁱ An exception in Table 2 is 'inherited disease', whose relevance appear to lie in an idea of *reducing inequalities* in life time health, but also compensating those who have been unlucky in the biological lottery.