

The Moral Relevance of Personal Characteristics in Setting Health Care Priorities

Professor Jan Abel Olsen

Institute of Community Medicine, University of Tromsø

Professor Jeff Richardson

Director, Health Economics Unit, Monash University

Professor Paul Dolan

Health Economics Group, University of Sheffield,

Professor Paul Menzel

Pacific Lutheran University, USA

May, 2002

ISSN 1325 0663

ISBN 1 876662 54 9

CENTRE PROFILE

The Centre for Health Program Evaluation (CHPE) is a research and teaching organisation established in 1990 to:

- undertake academic and applied research into health programs, health systems and current policy issues;
- develop appropriate evaluation methodologies; and
- promote the teaching of health economics and health program evaluation, in order to increase the supply of trained specialists and to improve the level of understanding of these disciplines within the health community.

The Centre comprises two independent research units, the Health Economics Unit (HEU) which is part of the Faculty of Business and Economics at Monash University, and the Program Evaluation Unit (PEU) which is part of the Department of Public Health at The University of Melbourne. The two units undertake their own individual work programs as well as collaborative research and teaching activities.

PUBLICATIONS

The views expressed in Centre publications are those of the author(s) and do not necessarily reflect the views of the Centre or its sponsors. Readers of publications are encouraged to contact the author(s) with comments, criticisms and suggestions.

A list of the Centre's papers is provided inside the back cover. Further information and copies of the papers may be obtained by contacting:

The Co-ordinator
Centre for Health Program Evaluation
PO Box 477
West Heidelberg Vic 3081, Australia
Telephone + 61 3 9496 4433/4434 **Facsimile** + 61 3 9496 4424
E-mail CHPE@BusEco.monash.edu.au
Or by downloading from our website
Web Address <http://chpe.buseco.monash.edu.au>

ACKNOWLEDGMENTS

The Health Economics Unit of the CHPE is supported by Monash University.

The Program Evaluation Unit of the CHPE is supported by The University of Melbourne.

Both units obtain supplementary funding through national competitive grants and contract research.

The research described in this paper is made possible through the support of these bodies.

Table of Contents

Abstract	i
1 Introduction	1
2 Some empirical evidence on peoples views on personal characteristics	1
3 Seeking explanations for the empirical findings	4
3.1 Utilitarian reasons.....	4
3.2 Egalitarian reasons.....	4
3.3 Desert and merit	5
3.4 Exogenous and endogenous causes	5
4 Causes of ill health and consequences of treatment	7
4.1 The starting point: outcomes and severity	7
4.2 The determinants of (ill) health.....	8
4.3 The consequences of treatment.....	10
5 Discussion and conclusion	10
References	14

List of Tables

Table 1	Personal characteristic that have been studied empirically.....	3
Table 2	The relevance/irrelevance of personal characteristic.....	12

List of Figures

Figure 1	'Need as ill-health' and 'need as capacity to benefit'.....	7
Figure 2	A framework of causes and consequences.....	9

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 inquire into the ethical reasons which might explain – and justify – the views expressed in these surveys. The paper develops a general framework on the *causes* of ill health and the *consequences* of treatment. It goes on to inquire into the extents to which a personal characteristic – and its eventual underlying ethical justification – could have any relationships to these *causes* and *consequences*. We attempt to disentangle those characteristics that may reflect a potentially relevant reason from those which violate widely accepted principles of social justice.

The Moral Relevance of Personal Characteristics in Setting Health Care Priorities

1 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 random surveys – wish to account for such characteristics when setting health care priorities (e.g. Charny et al, 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*: 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. 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 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 its eventual underlying ethical justification – 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.

2 Some empirical evidence on peoples 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; a person's expected health *gains* from treatment, her *severity* or her *age*.¹ While many empirical studies on personal characteristics have included age, we consider that to be related to a point in each person's lifetime as distinct from characteristics which separate one individual from another.

¹ For discussions of these characteristics, see e.g Nord, 1995, Williams, 1997, Dolan and Olsen, 2001.

Rather, the types of characteristics dealt with in this paper are principally 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 caused by own actions (e.g. smoking), and finally; 3) those that are 'embodied' in a *person's self* physically, intellectually or attitudinally (e.g. gender).

Based on a review by Dolan and Shaw (2001) we have identified surveys that have elicited peoples' views on the extents to which these types of characteristics should have any role in health care priority setting. Some of these surveys investigated potentially priority relevant variables that are outside the scope of this paper. Some inquired into general principles, while other put the issue within the context of a particular case, e.g. liver transplants. The question presented to respondents is whether a particular attribute should be taken into account when prioritising scarce health care between different people. The first column of Table 1 lists the personal characteristics – of the kinds dealt with in this paper – that were identified in these studies (including references to the study/studies). The second column gives the ordinal direction of any view on this characteristic, i.e. whether it was thought to give higher or lower priority. The third column gives the percentages of respondents in each study that answered 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.

Table 1 Personal characteristic that have been studied empirically

	Priority sign	% support
<i>A person's relations to others</i>		
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.
<i>A person's relation to (the cause of) the illness</i>		
'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%
<i>A person's self</i>		
man vs woman (1)	weak for latter	
men (2)	higher	3%
women (2)	higher	3%
homosexual (2)	lower	10%
race (2)	no priority	

(1) Charney et al, 1989,

(2) Dolan et al, 1999,

(3) Nord et al, 1995,

(4) Williams, 1988,

(5) Olsen and Richardson, 1998,

(6) Neuberger et al, 1998,

(7) Skitka and Tetlock, 1992,

(8) Mooney et al, 1995,

(9) Bowling, 1996,

(10) Edwards et al, 1999,

(11) Ratcliffe, 2000,

(12) Jowell et al, 1996.

Table 1 suggests that most characteristics that have been investigated into concern personal relationships to other people, economic relationships with the wider community, and aspects of 'self-inflicted' diseases. One should of course be cautious in comparing the percentage support across studies, because different wording have been used in the presentation of the same characteristic, different methodologies have been used when eliciting preferences, and different samples have been used. However, the picture that emerges is that people are *most* willing to favour parents of small children, and most willing to discriminate against substance users. People appear to be *least* willing to discriminate on characteristics related to a person's self, i.e. gender, race and sexual orientation.

Apart from the one result that showed 60% support for giving non-smokers higher priority, the remaining comparisons did not show majority support, i.e. they are consistent with a policy of not discriminating on the basis personal characteristics. Still, the minority supports for – and against – some of the characteristics in Table 1 are sufficiently large to warrant an inquiry into the possible reasons behind such views.

3 Seeking explanations for the empirical findings

The type of characteristics that deals with a person's *relations to other people* in society could either be considered *prospectively* by judging future consequences of treatment, or *retrospectively* in terms of desert (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 have thus a natural role in prospective reasoning, while the degree of socially meritorious behaviour reflects retrospective reasoning that is often vased in arguments that are ultimately neither utilitarian nor egalitarian.

3.1 Utilitarian reasons

From the utilitarian 'greatest happiness principle', all affected parties' changed utilities are to be included when assessing the goodness of a programme. The more total happiness that is generated, the more claims are there for health care. In the following we shall distinguish between *pecuniary* and *non-pecuniary* utility, implying a corresponding division between what might be termed '*pecuniary* utilitarianism' as opposed to '*non-pecuniary* utilitarianism'. When account is taken of the amount of happiness among others as generated through caring and personal interaction, that can be referred to as *non-pecuniary* utilitarian reasons. 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* utilitarian reasons refers to accounting for 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 letting some people have more claims on health care have recently been suggested by Edgar *et al* (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'. While many types of discriminations 'would in principle be possible' on utilitarian grounds, they may be inequitable as judged by egalitarian principles.

3.2 Egalitarian reasons

Egalitarianism involves preferences for equal shares across individuals of the entity that is to be distributed. There might be *general* egalitarianism favouring equal distributions of utility or well-being, or more *specific* egalitarianism related to – in this case – health care or health. Thus, a preference for giving priority to people with a particular personal characteristic might be compensation for disadvantages in other walks of life, for example poverty or low socio-economic status. Giving *higher* priority to such groups would then act as compensation for deprivation and reduce inequalities in well-being. Conversely, giving *lower* priority to rich or important people could be justified on the same grounds, but also on grounds that such groups are financially capable of paying for themselves. Hence, such priorities might reflect preferences for distributing

publicly funded health care with an additional aim of reducing inequalities in life-time well-being across different socio-economic groups.

3.3 Desert and merit

Le Grand (1987, 1991) holds that past actions should impact upon an individual's entitlement to health care; that honourable social actions make people more deserving later in life for health care, and that criminal activities should reduce one's entitlements. The empirical evidence suggested 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 whether the past actions have been *good or bad* suggests that society might look back in anger or honour when prioritising resources between individuals. This implies that the health service can make additional rewards or punishment – like an all mighty Supreme Court. However, a more convincing ethical argument to us, is that when atonement have 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 have – by definition – a connotation of altruism or duty to them, such as 'contributed a lot' or 'honourable'. 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 was 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 a parallel when looking retrospectively: 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 which differs from an idea of being a generally more deserving citizen due to past good actions which 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 in any way, i.e. voluntary efforts are more meritorious than paid.

3.4 Exogenous and endogenous causes

The second kind 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 et al (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 *reasons* in support of their assertions. The moral reasons we would suggest are based on our distinction between exogenous and endogenous causes of ill-health.

Equity and misfortune are the two sets of reasons for giving more weight to those who have suffered through factors outside own control, i.e. *exogenous causes*. As for equity, the issue is one of compensating for inequalities in life-time health or well-being. People with inherited diseases would initially have experienced less health, and so would people who are deprived due to the physical or social environment. Thus, there is a straight forward equity argument for giving more health care which would produce more QALY gains to these groups than to groups whose expected life-time health are greater, i.e. *compensation for deprivation*.

The other reason is more directly related to the exogenous nature of some factors. Misfortune – or ‘blameless’ is the flip-side of blame. Some have been *unlucky* in the biological lottery to be born with an inherited disease. And some have been the victims of external environmental factors, e.g. diseases mainly attributable to a poor working environment. A direct exogenous link would be if victim of an identified inflictor, e.g. being hit by a car on a pavement. In such cases of complete innocence, there appears to be an additional claim on health care. This implies *compensation for misfortune*.

As for *endogenous causes*, ill-health would rarely be entirely attributable to a person’s own actions. Even with ‘life-style diseases’ most variations in who contracts a disease are unexplained. Nevertheless, smokers are probably the most frequently used example of a group who contracts ‘self-inflicted’ diseases, for which – it is argued – they should be held personal responsible. There are two very 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 healthy; ‘risk aversion as a higher moral order’. Those who disobey would be punished by having less claims on health care.²

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 happens to be the least explored and yielding the lowest relative supports – give associations to various types of prejudices; such as sexism, homophobia, racism. Furthermore, suggesting that such characteristics should influence priority setting violates a key health policy objective of many countries’ public health services; i.e. that of *equal access for equal need*, independent of *inter alia* gender, sexual orientation, race. Within the general framework developed below, we inquire into the extents to which a personal characteristic – and its eventual underlying ethical justification – could have any relationships to the *causes* of ill health or the *consequences* of treatment. It turns out that personal characteristics embodied in a person’s self seem to fall outside this framework.

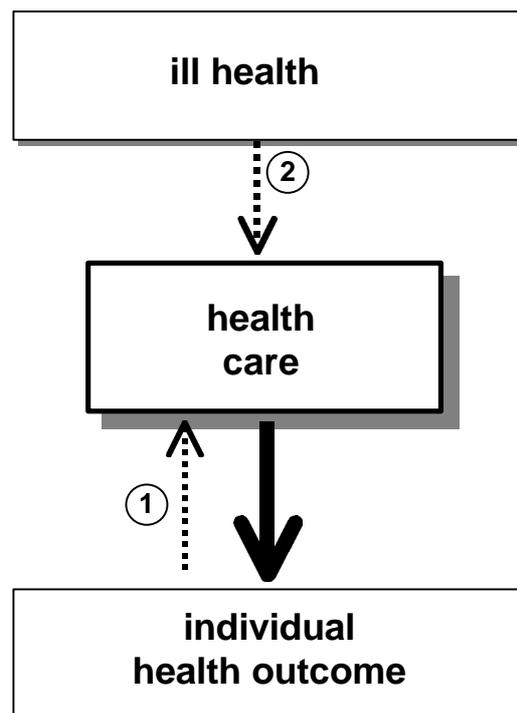
² See the concept of ‘healthism’ in Skrabanek, 1994.

4 Causes of ill health and consequences of treatment

4.1 The starting point: outcomes and severity

The discussion above suggests that a person's claims on health care could be determined by characteristics of that person *beyond* her health care needs. First, with respect to the policy objective of 'equal access for equal need', a clarification of the concept of *need* is needed (see e.g. Culyer and Wagstaff 1993, Olsen 1997). If need is interpreted as 'capacity to benefit', then what matters in determining one's claim for health care resources is the impact of health care on health gains – only. There is a causal production function relationship between health care and expected positive health outcomes. This argument is illustrated in Figure 1, in which the (bolded) *causation arrow* from health care to health outcomes determines the (dotted) *claim arrow* 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* which reflects a societal preference for prioritising the most severely ill patients.

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



The concept of *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 to be spelt 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, and , 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.

4.2 The determinants of (ill) health

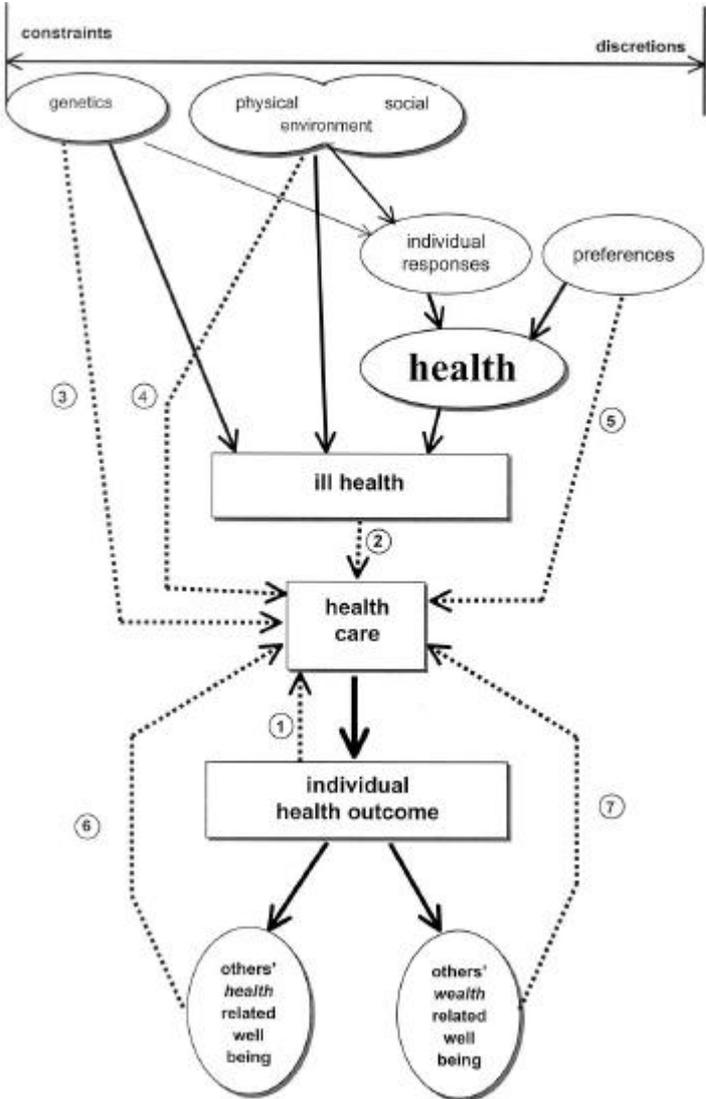
The framework for the determinants of ill health, as depicted in Figure 2, is influenced by some models by Evans and Stoddart (1990) that consider three determining factors; genetic endowment, the physical environment and the social environment, which produce 'host' responses in the individual. These responses, then, reflect 'social conditioning' as well as more biological reactions to the environment. The variable 'genetics' refer 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.

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 purely as revealing private sovereign choices. A more fruitful approach is to consider 'lifestyle' to be determined by factors over which individuals have *different degrees of discretion*, like a spectrum from constraints on the life one can possibly live to those factors over which one might have complete discretion. We have therefore completed 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 being 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 her sovereign preferences. While there are moral and ideological disagreements as to *which* actions a person should be held responsible for, i.e. whether it is a response or a choice, our suggestion that individuals have different *degrees* of autonomy when making lifestyle choices should be less controversial.

In the model illustrated in Figure 2, there are three exogenous 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 arrows between each of them are not drawn in this figure (e.g. there could be an arrow from preferences to social environment to reflect the view that people to some extent choose their environment.) Among these exogenous determinants, genetics and environment are – in principle – directly observable, while preferences are not. The way preferences become observable is in the lifestyle, but again, this lifestyle is influenced by individual responses to the former exogenous determinants. 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 a *health related* causality, such as diet, exercise and substance use.

Figure 2 A framework of causes and consequences



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) are 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 reasons for assigning more or less claims on health care. It appears that society consider people who have suffered from misfortune by nature to have more claims, as illustrated by the claim arrow . Among the personal characteristics listed in Table 1, ‘inherited disease’ would be one associated with this claim arrow. The claim arrow indicates compensation for various kinds of exogenous environmental causes, most often related to social deprivations. The personal characteristics in Table 1 that we would associate with this claim arrow are; ‘deprived in other ways’, ‘lower socio-economic status’, ‘poor’, ‘unemployed’.

Conversely, the suggestion to assign ‘rich’ people lower priority might be explained by ideas that such people are fortunate in other respects, or that they are able to pay for themselves.

The claim arrow suggests a view that people should be held responsible for their own actions. To the extent that a person – based on her preferences – has chosen a particular unhealthy lifestyle, they are then to be punished by less claims on health care; ‘self-inflicted ill health’, ‘contribute to their own illness’. Conversely, Table 1 suggest that those who ‘have taken care of their own health’ should be rewarded. The remaining characteristics under the heading *A person’s relation to (the cause of) ill health* in Table 1 reveal various degrees of blame for lifestyles with ‘unhealthy diet’, ‘rarely exercise’ or substance use. These views appear to reflect a perception of these factors to be of a kind that individuals have fairly wide discretions over; 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.

4.3 The consequences of treatment

There appears to be two different types of consequences for other people resulting from an individual’s improved health. The first deals with the *personal* impact on those other people with whom one has a personal relationship, i.e. the non-pecuniary benefits. The second type refers to the pecuniary impacts. In Figure 2, a distinction is made between consequences on other peoples’ *health* related wellbeing, and on other peoples’ *wealth* related wellbeing.³ It follows that the more positive impacts of the former kind, the higher claims – based on the above concept of *non-pecuniary utilitarianism* – would the person have on health care; arrow . And, the more economic contributions to society (termed ‘indirect benefits’ or ‘production gains’ in the economic evaluation literature), the higher one’s claims on health care; arrow . This arrow would then be justified by the notion of *pecuniary utilitarianism*. Going back to Table 1 again, the former would be associated with personal characteristics such as ‘have children’, ‘caring for elderly relatives’ and ‘married’, while the latter would refer to ‘breadwinner’, ‘employed people’.

Comparing the percentage support reported in Table 1, people seem to believe that the personal impacts represent more legitimate claims than the economic impacts. This could be explained by different degrees of replaceability. With regard to the personal impacts one has on friends and family, an individual is largely irreplaceable. However, we are all replaceable with regard to economic impacts (e.g. being breadwinners and tax-payers).

5 Discussion and conclusion

The issue of taking account of certain differences in personal characteristics when setting health care priorities is indeed problematic, both conceptually and practically. Traditional economics avoids the moral problem by the principle of the sanctity of consumer sovereignty in which ‘preferences are preferences’ – that is, whatever characteristics people want to count should count. No attempts are made to distinguish between prejudices and ethically defensible reasons. 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 to setting health care priorities.

³ We are not accounting for *own* wealth related well-being as generated from increased income. The reasons for excluding such outcomes would either be the ‘double counting’-argument (Weinstein et al, 1997) or the normative view that differences in own consumption should be ignored; otherwise, the higher own personal consumption, the more claim on health care (Olsen and Richardson, 1999).

In this paper, we have tried to separate out those personal characteristics which have *potential* moral relevance from those which are 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. Beyond this framework, the relevance of the different characteristics that have been studied empirically (Table 1) is now summed up in Table 2 and ‘cross-checked’ against various ethical reasons. The first three columns reflect consequentialism. The *utilitarian* reasons have in this paper been subdivided into being of pecuniary or non-pecuniary kinds. The egalitarian reasons involve attempts at offsetting inequalities in health or well-being. The last two columns have a non-consequential basis. There are two reasons for retrospection into past actions; *desert (and blame)* refer to the issue of whether a person’s interaction with other people have been meritorious or blameworthy, and; *responsibility* which refer to the extent to which the person could be held responsible for her ill health through past unhealthy behaviour.

We can think of a range of well founded reasons against having particular personal characteristics count when determining entitlements to health care might reflect. 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 if that would come into conflict with widely shared community values, which could be signified in general health policy objectives such as access independently of the particular characteristic.

Table 2 The relevance/irrelevance of personal characteristic

	Ethical reasons				
	Utilitarian		Egalitarian	Past actions	
	Pecuniary	Non-pecuniary		Desert re others	Responsibility 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					
homosexual					
race					

The first three characteristics in Table 2 have relevance from a non-pecuniary utilitarian reason (+ in the second column), but the first of them appears to be weakest. A counter argument is a principle of equal rights independent of marital status. 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. 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 on '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, i.e. how we relate to other people in society might influence our entitlements to public goods. 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) (+ in the fourth column, signalling that desert/blame reasons are relevant). 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 well-being of fellow citizens, is the idea of desert morally relevant. As for past criminal behaviour, it seems that only when atonement has not yet been made might one's entitlements be reduced. Otherwise, good and bad past actions should be 'cleared' in the relevant spheres and sectors of the society; in terms of honour and social approval, or in terms of punishments within the legal system. It is not for the health service to assign limited or increased entitlements to its services depending on differences in past (unrelated) actions.

The second type of personal characteristics concern a person's relation to the illness, and are justified primarily on the ground that people have a responsibility to live a healthy life.⁴ Of the different characteristics discussed in this paper, the one which is most hotly debated is whether 'self-inflicted ill health' should reduce a person's claims for health care (+ in the fifth column, signalling that responsibility reasons are relevant). The flip side – whether those who have 'taken care of own health' and thereby increased their claims – is based on the same ethical argument, namely that we have a duty to live a healthy life and avoid unnecessary use of collective resources.

The counter arguments are of two kinds. First, from Figure 2, many would argue that health related lifestyle is better described as an individual's response to the environment and social conditioning, than a reflection of sovereign choices. At a population level, a strong socio-economic gradient exists to explain a large degree of variations in individual health related lifestyle preferences. In any case, socio-economic variations often explain more of the variation in health than preference related lifestyle variations. Thus, giving higher priority to those who lead healthy lives implies more weight to the socially fortunate. Conversely, less priority to unhealthy behaviour implies 'victim-blaming' of people living in socially unfortunate environments (– in the third column because such a policy might accentuate inequalities). The second argument against letting lifestyle matter appears to have a basis in medical ethics; what matters is the state one is in – not the cause of the disease.⁵ As to the characteristic 'illegal drug', the reason for letting this have an impact is again that of personal (ir)responsibility; drug users should know that these substances are detrimental to their health. Furthermore, a rights based reason would be that such behaviour is – by definition – illegal. However, a counter argument which is also based on the notion of just procedures is that the health service is there to treat people in need, not to pass verdicts on people whose substance abuse is illegal.

It is hard to find any ethical reason which might justify the moral relevance of the third kind of personal characteristics related to a person's self. They all violate important principles of human tolerance.

We have not sought to consider the practical implications of the various moral arguments considered in this paper and, of course, it may be impractical to attempt to implement policies suggested by ethical arguments. The framework illustrated in Figure 2 might still be used when determining the extent to which more or less health care funding should be allocated to certain programme areas over and above that suggested by conventional cost-effectiveness analyses. For example, more health care could be allocated to those in worse health (arrow). Or more could be allocated to handicapped or deprived groups for compensatory reasons (arrows and), or more resources could be spent on changing the environmental determinants of unhealthy behaviour. As to those aspects of lifestyle on which people have significant personal discretion (e.g. diet, exercise, smoking – see arrow), information campaigns and the price mechanism could be used to alter individual choices. Some countries have already implemented programmes by which the health service give higher priority depending on 'social worth'. In Norway, patients who can return to work earlier would in some instances get preferential treatment (arrow).

⁴ 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.

⁵ A Norwegian Commission on Priority Setting in Health Care held that citizens should have equal rights to health care independent of their past health related behaviour. They argued that it is not for the curative sector to punish past behaviour, but for the preventive sector to alter future behaviour.

This practice seems in contradiction to peoples' views that differences in economic contributions are irrelevant, while differences in social and personal impacts are more relevant (arrow). More research is necessary to sustain or reject this apparent contradiction.

More generally there has been too little empirical research to draw strong conclusions about peoples' social preferences. There has been even less research to distinguish ethical based considerations from prejudices. Constructive research should focus upon the former only but to achieve this would probably require greater emphasis upon qualitative research designed to probe people's beliefs and motivations. In this paper, we have attempted to lay out an overview which might be considered a preliminary moral analysis for future research.

References

- Bowling, A. 1996. 'Health care rationing: the public's debate'. *British Medical Journal* 312: 670-673.
- Broome, J. 1991. *Weighting goods*. Oxford: Blackwell
- Charny, M.C., Lewis, P.A. and Farrow, S.C. 1989. 'Choosing who shall not be treated in the NHS'. *Social Science and Medicine* 28: 1331-1338.
- Cookson, R. and Dolan, P. 2000. 'Public views on health care rationing: a group discussion study' *Health Policy* (forthcoming).
- Dolan, P. and Cookson, R. 2000. 'A qualitative study into the extent to which health gain matters' *Health Policy* (forthcoming).
- Dolan, P., Cookson, R. and Ferguson, B. 1999. 'Effect of discussion and deliberation on the public's views of priority setting in health care: focus group study'. *British Medical Journal* 318: 916-919.
- Dolan, P. and Shaw, R. 2000. People's preferences regarding the equity-efficiency trade-off in health, *Mimeo*, University of Sheffield
- Dolan, P. and Olsen, J.A. 1999. Desperately seeking numbers: the not-so-holy grail of the 'super-QALY'. *Mimeo* University of Sheffield.
- Dolan, P. and Olsen, J.A. 2001. Equity in health: the importance of different health streams, *Journal of Health Economics* 5: 823-834.
- Edgar, A., Salek, S., Shickle, D. And Cohen. D. 1998. *The ethical QALY: Ethical issues in healthcare resource allocation*, Euromed Communications, Haslemere, UK
- Edwards, R., Boland, A., Wilkinson, C., Cohen, D. and Williams, J. 1999. 'Choosing explicit criteria for the prioritisation of elective NHS waiting lists: survey evidence of clinical and lay preferences from Wales'. *Paper presented to the Health Economists' Study Group Conference, University of Birmingham, January 1999*.
- Evans, R.G. 1984. *Strained mercy: The economics of Canadian health care*, Butterworths, Toronto.
- Evans, R.G. and Stoddart, G.L. 1990. Producing health, consuming health care. *Social Science and Medicine*, 31:1347-63
- Jowell, R., Curtice, J., Park, A., Brook, L. and Thomson, K., 1996, *British Social Attitudes: the 13th report*
- Le Grand, J. 1987. Equity, health and health care. *Social Justice Research* 1: 257-274.
- Le Grand, J. 1991. *Equity and Choice*. London: Harper Collins.

-
- Menzel, P. 1990. *Strong Medicine: The Ethical Rationing of Health Care*. New York: Oxford University Press
- Mooney, G., 1998. 'Communitarian claims' as an ethical basis for allocating health care resources. *Social Science and Medicine* 47: 1171-1180.
- Mooney, G., Jan, S. and Wiseman, V., 1995. Examining preferences for health gains, *Health Care Analysis* 3, 261-265.
- Neuberger, J., Adams, D., MacMaster, P., Maidment, A., Speed, M. 1998. 'Assessing priorities for allocation of donor liver grafts: survey of public and clinicians'. *British Medical Journal* 317:172-175.
- Nord, E. 1993. 'The trade-off between the severity of illness and treatment effect in cost-value analysis of health care'. *Health Policy* 24: 227-238.
- Nord, E., Richardson, J., Street, A., Kuhse, H. and Singer, P. 1995. 'Maximising health benefits vs egalitarianism: an Australian survey of health issues'. *Social Science and Medicine* 41: 1429-1437.
- Olsen, J.A. 1997. Theories of justice and their implications for priority setting in health care. *Journal of Health Economics* 16: 625-639.
- Olsen, J.A. and Richardson, J. 1998. Priority setting in the public health service: results of an Australian survey. *Technical Report 9*, Centre for Health Program Evaluation, Monash University, Melbourne
- Olsen, J.A. and Richardson, J. 1999. Production gains from health care: what should be included in cost-effectiveness analyses? *Social Science and Medicine* 49: 17-26
- Ratcliffe, J. 2000. 'Public preferences for the allocation of donor liver grafts for transplantation'. *Health Economics (forthcoming)*.
- Skitka, L.J. and Tetlock, P.E. 1992. 'Allocating scarce resources: a contingency model of distributive justice'. *Journal of Experimental Social Psychology* 28: 491-522.
- Titmuss, R.M. 1970. *The gift relationship*, London, Penguin
- Weinstein, M.C., Siegel, J.E, Garber, A.M., Lipscombe, J. Luce, B.R., Manning, W.G. and Torrance, G. 1997. Productivity costs, time costs and health related quality of life: A response to the Erasmus Group. *Health Economics* 6: 505-510
- Williams, A. 1988. 'Ethics and efficiency in the provision of health care' in Bell, M. and Mendus, S. (eds.) *Philosophy and Medical Welfare*. Cambridge: Cambridge University Press.
- Williams, A. 1997. Intergenerational equity: an exploration of the 'fair innings' argument. *Health Economics* 6: 117-132.