QALYS AND ETHICS: A HEALTH ECONOMIST’S PERSPECTIVE

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Abstract—Objectors on ethical grounds to the use of QALYs in priority-setting in public health care systems are here categorised as (1) those who reject all collective priority-setting as unethical; (2) those who accept the need for collective priority-setting but believe that it is contrary to medical ethics; (3) those who accept the need for collective priority-setting in principle, but are unwilling to specify how it should be done in practice. It is argued that the first two groups of objectors are simply wrong, if distributive justice is a proper ethical concern in this context. The third group is of more interest, as this group appears to believe that QALYs are unethical because it is unethical to regard QALY maximisation as the sole objective of the health care system. This paper argues that QALYs are relevant to a much wider range of objectives than QALY maximisation, and that they can accommodate a wide variety of health dimensions and sources of valuation. They can also accommodate the differential weighting of benefits according to who gets them, so they do not commit their users to any particular notion of distributive justice. What they do commit their users to is the notion that the health of people is a central concept in priority-setting, and that it is desirable, for reasons of accountability, to have the bases for such priority-setting made as precise and explicit as possible. The fourth group of objectors needs to acknowledge that there is no perfect system on offer, and since priority-setting does and will proceed willy-nilly we cannot wait until there is. It would be more constructive to set up the desiderata that a priority-setting system should ideally fulfil, and then appraise all feasible alternatives (including the status quo) even-handedly by those criteria. None will be perfect, but this author predicts that QALYs would emerge from such an appraisal with a significant role to play. Copyright © 1996 Elsevier Science Ltd

Key words—ethics, priority-setting, QALYs, rationing

OBJECTIVES

The purpose of this paper is to examine some of the arguments that have been put forward to support the claim that it is unethical to use QALYs in priority-setting in health care. I shall first describe the essence of the QALY concept, and then set out my views on the nature and purpose of ethical discourse. The core of the paper then follows, in which I shall categorise those who object to QALYs on ethical grounds as follows:

(1) those who reject all collective priority-setting as unethical;

(2) those who accept the need for collective priority-setting but believe that it is contrary to medical ethics;

(3) those who accept the need for collective priority-setting and do not believe that it is contrary to medical ethics, but reject the role of QALYs in it on other ethical grounds; and

(4) those who accept the need for collective priority-setting in principle, but are unwilling to specify how it should be done in practice.

By “collective priority-setting” I mean priority-setting intended to guide the use of public resources devoted to health care.†

I will mostly be concerned with such priority-setting at a “policy” or “planning” level, but when the occasion demands I will also consider its implications at a clinical level (e.g. in influencing decisions made by individual doctors about individual patients).

COLLECTIVE PRIORITY-SETTING AND THE QALY

In the presence of scarcity, resources devoted to the health care of one person will be denied some other person who might have benefited from them.‡ Clinicians are quite used to this phenomenon with respect to the allocation of their own time, and of any other resources that they control as practice managers. They are trained to discriminate between those who

*There are, of course, other possible grounds for objecting to QALYs, such as the practical problems in calculating and applying them. These practical problems will not be addressed here, since the ethical objections are prior. If they are valid, the practical problems become irrelevant.

†This paper is not concerned with the problem of priority-setting in private health care systems, which is examined elsewhere (see [1], [2]).

‡Throughout this paper I shall assume that each and every health care activity is being provided efficiently, in the sense that it does not use more resources than are absolutely necessary. I do not believe that this is in fact the case in any health care system, and I also believe that such inefficiency is unethical, in that it unavoidably deprives people of beneficial health care. But I wish here to concentrate on a more difficult problem, namely how best to choose between efficiently produced health care activities.

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will benefit greatly from treatment and those who won't, and by this means, "clinical priorities" are established, which are based on some broad assessment of risks, benefits and costs. The role of costs here is crucial, because they represent sacrifices made by other potential patients who did not get treated. Thus, the economists' argument that medical practice should concentrate on those treatments that are known to be cost-effective is designed to ensure that the benefits gained by those to whom treatments are offered are greater than the benefits sacrificed by those who are denied treatment. That is what "doing as much good as possible with our limited resources" means.

Priority-setting is inevitably painful, and its consequences are bound to be unfortunate for someone or other. It is, therefore, understandable that many people cling to the romantic illusion that if only more resources were devoted to health care they can escape from the process altogether.* But when more resources are made available, we still have to decide which are the highest priority uses to which these additional resources should be put. This too requires us to think carefully about collective priority-setting, so it is not really an escape route at all.

Collective priority-setting requires us to be able to compare systematically the benefits of different kinds of health care, provided in different settings, by different clinicians, for patients with different characteristics, suffering from different conditions at different levels of severity. This requires a benefit measure that is extremely versatile, and which has interval scale measurement properties (so that we can compare the size of differences in levels of benefit between treatments). Any measure that fails to fulfill these rather stringent requirements will be inadequate in principle as an aid to priority-setting.

QALYs were designed to serve that purpose [6], [7], but they require one further prior commitment, namely that the benefits of health care relate to both a person's length of life and a person's quality of life. We know that people value both of these fundamental attributes of life, so we need a measure of benefit that incorporates both and reflects the fact that most people are willing to sacrifice some quality of life in order to gain some additional life expectancy, and vice versa.†

If some health care activity would give someone an extra year of healthy life expectancy, then that would be counted as one QALY. But if the best we can do is provide someone with an additional year in a rather poor state of health, that would count as less than one QALY and would be lower the worse the health state is. Thus, the QALY is to be contrasted with measures such as "survival rates", commonly used as the sole success criteria in clinical trials, which implicitly assume that only life expectancy is of any concern to people. The essence of the QALY concept is that effects on life expectancy and effects on quality of life are brought together in a single measure, and the bulk of the empirical work involved in making the concept operational is concerned with eliciting the values that people attach to different health states, and the extent to which they regard them as better or worse than being dead. Conventionally, being dead is regarded as

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*Harris, for instance, in his book *The Value of Life* [3], after devoting 20 pages to discussing the pros and cons of different principles that might be used in priority-setting, finally comes to the section headed "What should we do?" and concludes lamely "The most moral and the most honourable way of dealing with the difficulties...is to try to ensure that we have sufficient resources to devote to postponing death, wherever and whenever we can, whether for long or for short periods, so that we do not have to choose between people invidiously". And when all of our resources have been devoted to giving everyone more 'good' life? More recently, and in a more pragmatic vein, Hancock writes: "Given the difficulty of finding a basis for rational rationing decisions and of commanding consensus in the community...we need to consider whether the present system could be re-examined and managed more efficiently and with greater fairness". She goes on to suggest that this be done "Assuming that the demand for health care is not infinite; that it does not outstrip resources; and that it may not in fact require a huge injection of resources..." [4]. One must applaud the desire to re-examine the efficiency and equity of the present system, which is precisely what QALYs are designed to assist, but if the demand for health care does not outstrip resources the problem no longer exists, so that does not seem to be the best basis for such a re-examination. Also, there is no evidence whatever from international experience to suggest that a minor increase in the proportion of GNP devoted to health care will eliminate the need for priority-setting. Even La Puma [5] seems anxious to evade the issues raised by his critics by recourse to the notion that "Physicians and policymakers should work together to understand each other's ideas and to serve patients without rationing the care that they need" (emphasis supplied). If discussion alone could resolve the problems, we would have solved them by now.

† do not here distinguish between QALYs and allegedly rival concepts such as Healthy Year Equivalents (HYEs) since they are best seen as different variants of the same general approach (see [8]) and they raise the same ethical issues as are considered here.

‡Explicit recognition of this as a trade-off problem immediately creates problems for those who believe that any and every life-threatening condition should take absolute priority over any and every non-life-threatening condition. Harris himself seems uncertain about his position here. He starts by arguing that it is lives that have to be saved, not life years. He then criticises the QALY approach for trying to maximise life years, observing that with that objective "the best thing we can do is to devote our resources to increasing the population". Without any apparent evidence for this proposition, he goes on to assert that "birth control, abortion and sex education come out very badly on the QALY scale of priorities", forgetting that what QALY maximisation is about is *quality-adjusted* life years, by which criterion one could doubtless make out a very good case for all three of those activities. A little later some doubts seem to creep in, however, for he concedes that "while it may be that life saving should not *always* have priority over life enhancement, the dangers of adopting QALYs which regard only one dimension of the rival claims...as morally relevant should be clear enough." But as will be argued later, QALYs can embrace any dimension of health-related quality of life that people think important and can be modified to reflect a wide range of equity concerns too.
THE NATURE AND PURPOSE OF ETHICAL DISCOURSE

This is a large and forbidding topic, and I embark upon it only to make clear to the reader my own perceptions. I see ethics as being about what is right and wrong in a moral rather than in a factual sense. I see all ethical principles as "relative" (i.e. no one principle "trumps" all others). The ethical principles that are of greatest interest in the context of collective priority-setting are those concerned with distributive justice. When applied to publicly financed health care, they typically have strong (but poorly defined) egalitarian foundations.* And in a democratic society they also rest on a notion of "consent", if not "consensus". In defining what is "just" (or "fair") no-one expects unanimity, for justice is an "essentially contestable" concept [12]. By this is meant that "there are competing conceptions of justice, all of which have respectable arguments in their favour" ( [12], p. 86).

What then is the role of "ethical discourse"? I take it to be clarificatory. It enables us to explore the implications of any principle or choice we might advocate, so as to ensure that we really do understand and accept them. For if we do not, then the principle is insufficient (and perhaps even totally inappropriate) or the choice is wrong (in the sense of not being in accordance with the principles we believe we hold). This clarificatory role is very important and to be welcomed wholeheartedly.

*The crucial unresolved problem being to specify what it is that is to be held to be equal between people (see [10], [11]).
†I have not found any such commentaries. If you know of any that come at all close to meeting my desiderata, please send them to me!

But I observe "ethical discourse" also being used for a different purpose, which is to argue (or often simply to assert or imply) that one ethical position is superior to another. Thus, what is engaged upon is not an ethical discourse but a political discourse (i.e. an attempt to persuade people to support one position rather than another) by labelling one "ethical" and the other "unethical", whereas the truth is that each is "ethical" according to its own associated conception of right and wrong. It is, of course, perfectly proper, indeed important, that those versed in the discipline of philosophical argument should engage the public in discussions about the basic principles underlying health care policy. But this requires some analytical detachment if "expertise" is being claimed, otherwise the role of the "expert" becomes a cover under which special pleading is made for the kind of health care system that that individual (as a citizen) would like to have, or for that class of person that that individual (as a citizen) would prefer to have favoured.

It is, of course, very difficult for any of us to maintain that detachment, and we doubtless all slip up at times, but I see one of the benefits of ethical discourse as being to point out to the unsuspecting that they are being asked to subscribe to a position that they might not wish to hold. Much of the ethical critique of QALYs has had precisely this objective in mind, and the resulting discussion has been very enlightening. My criticisms of it will be based on two general propositions. The first is that most commentators seem to believe that the ethical commitments that the QALY concept requires are narrower than they really are. This may be partly due to the fact that the empirical work that has so far been done has had to be based on certain simplifying assumptions, which may have led commentators to believe that these simplifying assumptions are intrinsic to the concept, when in fact they are not. The second is that these critiques have typically been conducted in a rather unsystematic way. To conduct a systematic critique requires the setting of prior criteria of judgement (which, because of the "essentially contestable" nature of the subject matter, would need to be quite broad-ranging), and then the comparison (in principle) of QALY-based priority-setting with non-QALY-based ("Brand X") priority-setting. I would then expect that QALYs would show up better than "Brand X" on some criteria, but worse than "Brand X" on other criteria. It would then be left to the reader (as a citizen) to decide which of the respective merits and demerits are more important. But if this level of detachment is too much to hope for in such contentious territory, one might at least expect the analysis to be clearly separated from the advocacy.
IS COLLECTIVE PRIORITY-SETTING UNETHICAL PER SE?

Those who reject all collective priority-setting as unethical typically assert that it is immoral for one person to sit in judgment on the worth of other people's lives, which is what collective priority-setting appears to require us to do.* However, since they accept the fact of scarcity, they acknowledge that some people must be denied the benefits of health care, but they want that done in a manner which is free of any interpersonal judgments of relative worth. They believe that this can be done by recourse to a lottery.† The trouble with this supposed solution is that lotteries do not fall like manna from heaven, but have to be devised and run by people, who have to determine who shall be eligible, when, and under what conditions, for each and every treatment that is on offer [18]. So recourse to a lottery simply brings us back to the very same priority-setting issues that it was supposed to avoid. Ultimately, someone has to make a conscious decision on how best to discriminate between people when confronted with scarcity. The problems then simply re-appear in a different context.

Instead of seeking to avoid the making of interpersonal judgments of life's value, it seems more fruitful to try to achieve as much detachment as possible when making them. An entirely different sort of lottery could have an important role to play in that process. What I have in mind is the thought experiment involved in approaching collective priority-setting from behind the "veil of ignorance" [19]. We have to imagine ourselves outside the society of which we are members, and then choose that set of rules for collective priority-setting which would be most likely to achieve the distribution of health benefits that we think best for our society. Then, and only then, will we be assigned, by lottery, an actual place in that society. We may find ourselves favoured by our rules, or we may be one of the unfortunate people who are disadvantaged by them, but we would have achieved a set of rules that we would have to accept as fair.

IS COLLECTIVE PRIORITY-SETTING CONTRARY TO MEDICAL ETHICS?

My second group of objectors are those who accept the need for collective priority-setting, but believe that it is contrary to medical ethics. In the extreme, such people believe that it is the doctor's duty to do everything possible for the patient in front of him or her, no matter what the costs [20]. But in a resource-constrained system "cost" means "sacrifice" (in this case the benefits foregone by the person who did not get treated). Thus, "no matter what the costs" means "no matter what the sacrifices borne by others". If medical ethics include an injunction to deal justly with patients [21], then there has to be some weighing of the benefits to one person against the sacrifices of another. So I think that this supposed ethical conflict between the economists' argument that costs (i.e. sacrifices) must be taken into account in every treatment decision, and the precepts of medical ethics, is non-existent, because medical ethics does not require everything possible to be done for one patient no matter what the consequences for any of the others.

WHY MIGHT THE QALY APPROACH TO COLLECTIVE PRIORITY-SETTING BE UNACCEPTABLE?

My third group of objectors consists of those who accept the need for collective priority-setting, and do not believe that it is contrary to medical ethics, but cannot accept the QALY approach to it on other ethical grounds. There seem to be four distinct ethical issues raised here. First, whose values should count? Second, how should we move from individual values to group values? Third, should we not be concerned with the distribution of the benefits of health care across different people, as well as with the total amount of such benefits? Fourth, are there other benefits from health care that QALYs do not pick up? I will tackle each of these in turn.

Is the QALY approach unacceptable because it uses the wrong people's values?

In principle the QALY concept is extremely accommodating in that it can accept anybody's views about what is important in health-related quality of life, and anybody's views about the trade-off between length and quality of life. In practice, the early empirical work was based on professional judgments (mostly those of doctors). More recent work has been based on the views of patients and of the general public, and my own work has concentrated on the latter, because I am anxious to find out whether the values of the practitioners, their patients, and the general public coincide. What the QALY concept does, quite properly, is bring this question to the fore, and indicate the difficulties that are likely to arise if the priorities of a particular group of patients differ from those of their doctors or of the wider society of which they are part. In principle, since every treatment decision entails benefits to some and disbenefits to others, in a democratic society the views of all affected parties should count. Since the sacrifices involved in treating particular groups of patients will be widely spread and difficult to identify with any precision, this points inexorably to the general public as the most appropriate reference group. Some people have advocated using the values

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*Strictly speaking, it requires us only to sit in judgment on the value of changes in health-related aspects of people's lives. But for some people any interpersonal comparison of worth is unacceptable (e.g. [13]). I have argued for a long time that since such comparisons are unavoidable, the best strategy is to make them explicit (see [14]).
†See, for example, [13], p. 88. Harris's advocacy of lotteries has been endorsed by O'Donnell [15], who also believes them to be "a much more practical solution than the economists". My own views were set out in a letter to the editor entitled "QALYs or short straws" [16]. Evans also appears to regard this as a viable solution [17].
of a particular reference group as the collective view (e.g. the views of the most disadvantaged, or of people with particular moral, legal or political authority). This alternative position raises other obvious concerns about elitism in a supposedly democratic society. But adoption of the QALY approach does not require you to take sides in this particular dispute; it does, however, require you to be explicit about what the values are that are being used, and where they came from. That is an important contribution to the ethical discourse.

Is the QALY approach unacceptable because of the way it moves from individual to group values?

Once again, there is nothing in the QALY approach that requires aggregation to be conducted in any particular way. But collective priority-setting does require a collective view, so some method of aggregation has to be adopted, and whatever method is used, it will have strong ethical implications. The simplest method is to postulate that everybody’s views, however extreme, must be given equal weight, and a simple average is then taken to represent the collective view. A somewhat more complicated position is involved in taking the median view as the collective view. The median view is the one that would command a simple majority in a one-person-one-vote system. With a skewed distribution of values (which is what is commonly found) it gives less weight to extreme views than would the taking of a simple average. But whichever position is taken on this issue, the QALY approach has the great advantage that it is not possible to hide what you have done, so it is quite easy for others to tease out the ethical implications. Also, the implications of a non-populist stance are that some people’s views count for nothing, which itself would seem to require an ethical justification, since everybody’s welfare will be affected by collective priority-setting.

Something more has to be said here about the conflict between the clinical standpoint and the societal viewpoint, because many clinicians believe that it is unethical for them to replace the values of each individual patient with some collective set of values. That it creates an ethical dilemma for them cannot be denied. But it is one they have lived with for a long time: only in a purely private market (with no charity and no insurance) have doctors been in a position where they could do whatever the patient demanded (i.e. wanted and was willing to pay for). In all other circumstances doctors have been constrained by somebody else’s willingness to pay (e.g. insurers, friendly societies, voluntary hospitals, taxpayers) and by their own willingness to put in more of their own resources without being paid. So it seems to me that such protests are more political than ethical, by which I mean that they are a protest against increasing public demands for accountability in areas which previously were ones where the clinicians had unchallenged private discretion. The ethical grounds for resistance are in fact weak [24].

Is the QALY approach unacceptable because it ignores the interpersonal distribution of health gains?

My theme here is the same as before: there is nothing in the QALY approach that requires QALYs to be used only in a maximising context, although it is QALY maximisation that is the natural interpretation of the drive for efficiency in health care. But QALYs will also have a role in more complex rules, and more complex rules will almost certainly need if collective priority-setting is to reflect the views of the general public.

The simplest and commonest use of QALY calculations at present is based on the assumption that a year of healthy life expectancy is to be regarded as of equal value to everybody. Note that this does not say that it is of equal value to everybody, because that is unknowable. What it says is that if that social judgement is appropriate, then what follows from it will be appropriate. If it is not, then what follows will be irrelevant. A strong egalitarian case could be made for that assumption, since it implies that it does not matter at all who the beneficiary is. Like justice, it is blind. It pays no regard to race, sex, occupation, family circumstances, wealth or influence. In this respect it follows precisely the assumptions underlying the use of the more conventional outcome measures used in clinical trials, which simply count the number of people
with the specified outcome characteristic. But following hallowed tradition may not carry much weight if a sizeable majority of the general public would prefer some discrimination between potential beneficiaries according to their personal characteristics or circumstances.

For instance, there is evidence [26] that most people (including the elderly) would give extra weight to benefits accruing to young people over the same benefits accruing to old people. There is a similarly widespread view that people with young children should have some priority over their childless contemporaries. It is quite possible to build these differential weightings into QALY calculations, the implication being that instead of maximising unweighted QALYs, we would need to weight them according to the relative priority assigned to the particular characteristics of the beneficiary. Note that if this populist view is accepted,* it would count in favour of the simple QALY approach that it discriminates incidentally against the elderly, and not be an unethical implication at all.†

But it has also been argued that the interpersonal distribution of health gains should be influenced by how healthy people will be at the end of the process. For instance, it may be argued that our distributional concerns should not focus primarily on health gains, but on the level of health itself. That statement itself requires clarification as to whether it is people’s current health status that is to be the focus of concern, or their prospective health (e.g. disability-free life expectancy). The former may be taken to mean the current “quality adjustment” part of QALYs, and the latter the present value of a person’s expected future flow of QALYs. In either case QALY measurement will have a role to play, even though QALY maximisation is no longer the (sole) objective. The rationale for some equalisation of achieved health is typically a variant of the “fair innings” argument, namely that it would be wrong to devote resources to improving the health of those who have already had a long and healthy life when those resources could be used to improve the health of someone who otherwise will have a shorter and/or more unhealthy life. In weighing the benefits of health gains between people of different ages this consideration almost certainly lies behind having equity weights which favour the young, as discussed in the previous paragraph. But now the intention appears to be to go further, and advocate a more extreme form of discrimination against the older and healthier members of the community, by establishing an absolute (or at least a very strong) priority in favour of the more unfortunate over the less unfortunate, in the manner of Rawls [30]. It requires the eliciting of a co-efficient representing society’s degree of aversion to such inequality (which will tell us how great a sacrifice in the health of others we are willing to accept in the interests of this kind of equity).

Something similar seems to be implied by the “double jeopardy” argument.‡ The proposition is that being in a poor state of health, or having a past history of being in poor health, generates a moral claim that is independent of what can be done to improve it, and Nord [32] has found some evidence of support for this belief in a Norwegian population. If this belief proves to be widespread, the role of the QALY measure will be twofold. First, it will be necessary to estimate how bad is each person’s health state with and without treatment, in order to identify the most beneficial treatments. Then it will be necessary to look at how bad are the states that people have been in, so as to decide how best to arrange the distribution of health gains in order to make the consequential distribution of levels of health more acceptable. To do this will require the measurement in QALY terms of each person’s lifetime experience of health, and the generation of a coefficient representing society’s aversion to inequality in individual experiences of lifetime health. Once more QALYs play a key role, even though QALY maximisation is not the (sole) objective.

Is the QALY approach unacceptable because there are benefits from health care other than improvements in health?

There obviously are such benefits, in that the provision of health care generates a livelihood for millions of people, but what people usually have in mind here is more to do with the benefits to the consumers of health care rather than to its providers.

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*Since this is one of the “essentially contestable” aspects of distributive ethics, there will, as always, be a significant minority who disagree with the majority view. Elhauge, for instance, argues strongly against allowing such personal characteristics to play any role in the allocation system, which would bring us back to unweighted QALYs [27].

†Contrary to the argument of Harris [28], the arguments put forward by Evans for favouring the elderly are more complex [29]. After arguing impeccably that “We should aim to acquire enough information to be able to work out for each person, regardless of age, what the cost-benefit ratio of a contemplated intervention would be”, he concedes that “age may be associated, on average, with differences in outcome from treatment”, which implies that “on average” his cost-benefit ratios will (incidentally) discriminate against older people. But he then shrinks from accepting this, saying that “cost-effectiveness underlies the ethics of the purveyor rather than the customer”, seemingly forgetting that “effectiveness” is precisely about the benefits to “customers”, and that costs are about the sacrifices imposed on other potential “customers”. He then simply asserts that “Other things being equal, the 30 year old and the 80 year old will be equally grateful for having their lives saved”, even though that conclusion is unknowable, and the relevant matter is what the two individuals and the rest of society regard as just. His final conclusion that “there is no more equitable or open form of rationing than a good old fashioned orderly British queue” depends, of course, for its validity upon how people became eligible to join the queue, on who decided the priorities between them and on what grounds. Queues are like lotteries in that they are the result of someone’s decisions about priorities, not a way of avoiding those decisions.

‡As promoted, for instance, by Harris [28] and challenged by Singer et al. [31].
A more relevant claim in the current context is that people get satisfaction from health care in ways that do not show up as improved health. A key issue in clarifying what is at stake here is what is meant by "health". In the QALY context it is whatever aspect of health-related quality of life that is of value to people, and the length of that life. This is to be sharply differentiated from a narrow clinical definition of health, as concerned with whatever biomedical measures of physiological (or psychological) abnormality are of clinical relevance. Clearly the QALY will pick up many benefits from health care that may not show up in any narrow clinical assessment (though with the broadening of clinical criteria to include many quality-of-life issues, an increasing number of clinicians do in fact adopt a QALY-type approach to benefit measurement) [33]. Thus providing information or reassurance to people about a clinically incurable condition could well be evaluated within a QALY framework for its potentially favourable impact, as could "palliative" care. So the question is, are there other benefits that in principle the QALY concept will not pick up?

It is important to recall here that the present discussion is centred on priority-setting in a public health care system, so we are not specifically concerned with the broader issue of why one might prefer a public to a private system (which is usually based on the argument that the former determines priorities according to "need" and the latter according to the ability to pay, with all the distributional implications that have been discussed above). Most of the arguments about group participation, caring externalities and altruism relate to that choice rather than to the ones we are now considering [35]. They may also bear just as heavily on how equitable and efficient the tax system is that finances health care as on the distribution of the health care itself [36].

Where the crunch comes for collective priority-setting is whether concern about the process of providing and receiving health care is simply derived from any of the more fundamental concerns about outcomes which have already been discussed, or whether it is a legitimate focus for ethical concern in itself. To put the matter as starkly as possible, if we had in place a system that satisfied all our efficiency and equity goals as they relate to any aspect to do with people's health, would we have any additional ethical concerns about the impact of health care upon the welfare of its consumers?†

The usual focus of concern here has been accessibility: is there a legitimate ethical concern requiring people to have access to health care even if it will not improve their health (as measured in QALY terms)? The argument seems to turn on the extent to which it is right to divert health care resources away from improving people's health and to devote them instead to reinforcing people's sense of security about care being available to them when they need it. But if "need" means "capacity to benefit", and what is available will benefit people, and what is available is available on equal terms to everybody, what more ought to be done? All of these conditions would be fulfilled by a simple QALY-maximising system, and if the implied argument is that some people are more deserving than others, the only difference would be that we would need to use "equity-weighted" QALYS, or some co-efficient of aversion to inequality, to determine the terms on which health care is offered. But whichever of these systems is espoused, they require only that the distribution of health outcomes be taken into account. No extra rules about accessibility are required.

There is a broader argument that might also be considered here, namely that respecting the autonomy of the patient implies maximising the patient's satisfaction from health care. The counter argument is that priorities are set by the whole society, and that if what would give an individual satisfaction (e.g. getting a medical certificate to say that he is unfit for work when he is not) clashes with what society requires of the system, then it is the social norms that should prevail.

IS COLLECTIVE PRIORITY-SETTING NECESSARY IN PRINCIPLE BUT UNACCEPTABLE IN PRACTICE?

This brings me to my final set of people, those who accept the need for collective priority-setting in principle, but are unwilling to specify how it should be done in practice.‡ A typical stance is to point out all the difficulties involved with some particular approach, and then to sit on the fence waiting for the next candidate to come by, and then do the same. This would be fine if the implied ideal method were available to us, or if we could suspend all health care decision-making until it were. But there is no perfect system on offer, and we can not wait. As with a well-conducted clinical trial, the new has to be compared systematically, according to preselected criteria, with what already exists. This is what needs to happen in the field of priority-setting. If the same criteria as are used to criticise

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*In this respect La Puma and Lawlor [34] are mistaken when, after observing that "Patients often seek physicians for attention, information, reassurance, encouragement, and permission, not just prescriptions and procedures" they go on to assert that "In QALY's there is no attempt to integrate the therapeutic value and outcome of talking with patients or their families". But talking to patients and their families is a procedure, and its therapeutic outcome upon the length and quality of patients' lives (and those of their relatives) is precisely what QALYS are designed to measure!†This is how the issue is posed by Mooney [37], who asserts that "equality of access... is not considered relevant in QALY maximisation", but this is not true. If "need" means capacity to benefit, then "equal access for equal need" will be required for QALY maximisation, and the greater the need, the more important it will be to ensure access.‡A classic case is Carr-Hill; see, for example, [38] and the reply thereto by Williams [39].
the QALY approach were used in an even-handed way to criticise current practice, or any feasible alternative to it, how would these alternatives make out? It is irresponsible to do less.

WHAT IS THE NATURE OF THE "SOCIAL CONTRACT" IN THE FIELD OF HEALTH CARE?

I must, finally, venture into the territory of the political philosophers, and make a few remarks about the supposed nature of the "social contract" between the citizens and their (public) health care system. In doing so, we must bear in mind that the problem of collective priority-setting is central to that supposed contract, because it arises from the tension between each citizen's desire to have the best health care possible when he or she needs it, and the conflicting desire to have as good a length and quality of life as possible in all other respects at all other times. Thus, the tensions evident in the public debate merely reflect the tensions we all experience in our private lives, as patients on the one hand and as taxpayers on the other.

I see a "social contract" as the informal understanding reached between the members of a community as to what their responsibilities towards their fellow citizens are, and what the responsibilities of their fellow citizens towards them are. Some of these responsibilities are to be discharged directly between one individual and another, and others through various collective institutions set up for this purpose (e.g. a public health care system and its associated tax system). Once more it must be stressed that there are no overriding rights or responsibilities in this multidimensional world.* And different societies at different times will work within different "understandings", and not everyone in a given society at a given time will accept the general understanding that the majority has accepted. We are back to "essentially contested" concepts.

Harris [28] argues that the social contract has at its heart "the idea that we treat each person with the same concern and respect" and then, somewhat surprisingly in view of his advocacy elsewhere of lotteries, goes on to quote Dworkin approvingly as observing that "I do not show equal concern if I flip a coin to decide" whether to give the only dose of a drug to someone who will otherwise die rather than to someone who is merely uncomfortable. He says that treating people equally is not the same as treating them the same. This presumably goes back to Aristotle and the notion that equals are to be treated equally, and unequals unequally in proportion to the relevant inequality. The former is what is commonly called horizontal equity, and the latter vertical equity [40].

In this formulation of the social contract, everyone is to be treated with the same concern and respect in relation to what is relevant in the circumstances, and the role of the social contract is to define what is relevant. It may be that age is held to be relevant, but not race. It may be that capacity to benefit is held to be relevant but not income or wealth. A decision not to offer someone a particular treatment is ethical, and in accordance with the social contract, if everyone in the same relevant circumstances will also not be treated, provided that each individual's circumstances have been properly assessed, and the social contract was drawn up in a legitimate manner. There is nothing in the QALY approach that prevents us from treating each person with equal concern and respect in this sense. Indeed, careful measurement of health status in QALY terms might help to ensure a better assessment of an individual's circumstances, and a more acceptable and openly accountable way of deciding who shall and shall not be offered which treatments.

This brings us to the rub of the matter as far as the "social contract" idea is concerned, namely how it is to be determined in a legitimate manner. Menzel [41] argues that if collective priorities are based on the informed views of the general population about the prospective risks they are willing to take (as from behind the veil of ignorance?) with their health, then the likely QALY gains from different treatments will inevitably be part of that process. Note, however, that he believes that "informed consent" implies using valuations only from people who have actually experienced the health states in question, which may well restrict severely the number of people who are allowed to play a role in some parts of the process. But one could go a step further and ask people about which discriminations they consider "fair" and which "unfair", and here it is difficult to think of any good reason why any competent person should be excluded. This will probably expose an overwhelming consensus in favour of the young and in favour of those with young children when it comes to distributing the benefits of health care. Within the context of a contractarian approach to priority-setting, why should this be resisted (especially since the older members of the community share in that view)?

One further point needs to be mentioned, and that is the view that surveys, whether conducted by questionnaire or by individual interview, fail to capture the deliberative and reflective attributes intrinsic to any socially acceptable collective priority-setting. Would it not be better to rely on wide-ranging and deeply penetrating discussion amongst detached, well informed, and responsible people? Quite apart from how this panel is to be chosen (clearly not a random sample of the general population), two problems arise here. First, what evidence does this panel need from outside itself to ensure that it is in touch with the community on whose behalf it is acting? Second, what evidence does the community need from the panel to ensure that

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*For instance, it is not the case, in principle or practice, that "there are no financial constraints on society's obligation to attempt to ensure equality before the law" ([28], p. 119), for that would imply that the sacrifices borne by others would not be taken into account, which in turn implies a lack of concern or respect for their welfare.
whatever conclusions it comes to were arrived at in a manner that is acceptable to the wider community? Dealing with the first problem will surely require the manner that is acceptable to the wider community? whatever conclusions it comes to were arrived at in a high highlights. So it seems to me that the negotiation of a it has resolved all the issues that the QALY approach of health care requires the adoption of a QALY approach, for this is the approach that maximises the use of evidence, maximises participation, maximises openness, and offers the most comprehensive framework of thought for tackling the many ethical issues involved.

CONCLUSION

The essence of my argument in this paper is that although the QALY-based approach to collective priority-setting in health care is “consequentialist” (meaning that it emphasises the importance of measuring the impact of health care upon people’s health), it is not necessarily “utilitarian” (in the sense of requiring the objective to be the simple maximisation health gains). QALYs have a key role to play in any system of health care priority-setting in which the impact of health care upon people’s health is a relevant consideration. It is difficult to conceive of any ethical system of collective priority-setting for health care in which this would not be the case. Indeed, in most public systems it appears to be the dominant consideration [42]. It therefore seems to me that the QALY approach will become the dominant approach.

So let me end with my favourite Maurice Chevalier story. When he was getting quite old he was asked by a reporter how he viewed the ageing process. “Well,” he said “there is quite lot I don’t like about it, but it’s not so bad when you consider the alternative!” Perhaps the same is true of the QALY approach to collective priority-setting in health care. If so, we should beware of rejecting it simply because it falls short of perfection.

REFERENCES