

Opinion

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## **Public Health - Consent**

### **Health Care Rationing: The Prior Consent Approach**

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#### 1. INTRODUCTION

How should society ration out scarce health care resources? Should permanently comatose patients be kept alive if this prevents the community from funding quality of life enhancement treatments like hip replacements? One approach to deciding such matters is a cost-benefit utilitarianism where administrators play God in deciding which treatments should have priority. Another is a 'respect life at all costs' approach, no matter how serious the consequences of this are for quality of life. An alternative approach is the 'prior consent' approach advocated by Paul T Menzel in his book, 'Strong Medicine', which I describe below.

#### 2. THE PRIOR CONSENT APPROACH

Prior consent theory is part of the ethical and political tradition that takes autonomy and consent as the dominant values in moral theorizing. This tradition does not accept that it is the role of authorities such as governments to determine what kind of life should be the good life for a person. This is a matter that should be left in people's own hands, provided they give equal respect to the practice of other people's concept of the good life. The theory determines rationing in terms of what prospective patients would consent to rank as their more worthwhile kind of health care prior to their having need of either the higher or lower ranked service, or finding themselves in a lower-ranked rather than a higher-ranked category of patient. As a consequence, 'the crucial reason why Mary gets dialysis and Harry does not is not that any of us have judged him to be worth less than her. It is that Harry himself has endorsed the decision that her sort of life should be saved before his' (Menzel, p 17).

In effect, we are all to be conceived as subscribers to a 'voluntary, co-operative prepaid health plan' (p 10). We are assumed to be 'imaginative, informed' people (p 13). The health plan is to be understood as a form of health insurance and is one of a range of plans that the subscriber might purchase. This frees the subscriber (say, a woman) to determine how much of her income she is prepared to devote, not only to health as compared to other aspects of her life, but to protecting herself from one particular kind of health future as opposed to another. The theory recognises that, when the subscriber actually confronts a situation where she is at

risk of dying or suffering and the health policy she has chosen does not insure her for all possible care in these circumstances, then both she and her doctor will be strongly motivated to try to reverse her previous decision and get maximum care for her now. The model, however, requires her previous decision to stand or, if hypothetical consent was necessarily the basis of the ranking, that the arrangements it produced should stand. To do anything else is to permit a form of special pleading that renders any given prioritisation pointless.

Nonetheless, society may well require that everyone be insured at least for a certain minimum, a minimum funded for the poor from taxes collected from the wealthy, and that the poor not be free to divert this money into purposes other than health.

### 3. DETERMINING PRIOR CONSENT

As far as possible, decisions about rationing priorities should be based on appropriate empirical data. As not everyone can be asked, this means some form of sampling must be used. However, the sample must not only be representative of the population as a whole, it should take special cognisance of the population affected by the medical condition under consideration, that is, the rankings should be based on the first-hand experience of those who have undergone serious impairments, threats of death, and the relevant levels of pain

(p 89). This does not mean letting the options of those currently likely to want maximum care to be decisive but, rather, to ensure that the final determination is based on a proper appreciation of what subscribers will undergo if they do end up suffering from a condition they have not insured for. For example, it is important information for subscribers to take into account, or for their representatives to take into account on their behalf, 'that a significant number of patients themselves reject dialysis. Apparently they believe that the added life dialysis could bring is either so short or so low in quality that its value to them is essentially zero' (p 200).

What sorts of priorities might such a method determine? Menzel thinks that the prior consent model would give very low priority to keeping alive patients who everyone admits are permanently comatose. He illustrates this with the 1991 Minnesota case of Helga Wanglie. She had been in a coma since June 1990 and all involved parties agreed she would never regain consciousness. Whereas her doctors felt that life-sustaining care such as ventilator and feeding tubes was medically pointless, her family wanted it, largely on the grounds that she had said 'only He who gives life may take it'. By the time she died of an infection in July 1991, her care had cost about US\$1 million.

Now, suppose that some years prior to her coma Mrs Wanglie had had to decide what amount of her resources she would spend on medical insurance, and what

kinds of conditions she would insure for, including the option that she insure to cover herself in a permanently comatose condition at a cost of \$1 million a year for life. Surely, 'she would have preferred that the resources be spent on other things' (1992, p 162), even if she believed that comatose life had some value?

Perhaps the best way to get public discussion about rationing issues of this kind is to institutionalise the practice of excluding such marginal care openly and up front, putting the onus on subscribers who dissent to either seek alternative cover or to organise within a particular scheme and change its priorities. As Menzel says, 'That would test out the integrity of any claim that cost should be no object' (1992, p 163).

Would we give prior consent, however, to sacrifice life-saving treatments for merely life-enhancing treatments, given that 'relatively low-quality life can mean as much to a person faced with death as high-quality life?' (p 87). Menzel believes that we would. In fact he suggests we would give prior consent to rationing life-saving hemodialysis to provide more hip replacements. This is because he believes both that hip replacements significantly improve quality of life and that we would be prepared to put this improvement on the same scale as life itself. It is important to prove this latter point because the mere fact that one would prefer hip replacements that improve quality of life from 0.9 to 0.99 over something that improves life less, does not in itself show that you would prefer them to life itself.

Suppose, for example, one is prepared to take a gamble in one's own case of a 10 per cent chance of dying in order to have one's hip fixed. Doesn't this strongly suggest that one would take a 10 per cent risk of turning out to be a kidney failure victim who 'is not saved with dialysis in return for the greater chance of being someone who gets a hip replaced?' (p 88).

#### 4. CONCLUSION

Menzel uses the 'prior consent' approach to provide answers to such difficult questions as 'Do we have a duty to die cheaply?', 'What are the limits of care for seriously ill new-borns?', 'Should the rich be able to buy superior care?'. The approach, therefore, has clear practical value as well as the moral value of respecting autonomy and consent. It is worth serious consideration by anyone involved in health-care provision.

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