

Don't stop thinking about tomorrow

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Maybe you only have 1000 units of some resource, but 10,000 people need the resource or would benefit from it. One question: why do you control the resource? Leave that aside for now. A second question: how should you allocate the resource? If you are a decision-maker in a health system, and if the resource has to do with medicine or public health, we are in the world of the ethics of scarce resource allocation decisions in healthcare.

Munthe *et al*¹ note that the 'operational norms that guide actual decision making in this area tend to be similar across health systems' and include principles concerning need, prognosis, equal treatment and cost-effectiveness. Even with just these principles, there are hard questions of how they ought to be specified, operationalised and balanced against each other when they conflict. They do not focus on this.

Instead, they identify a concern: paying attention only to these principles in making allocation decisions may lead decision-makers to miss 'negative dynamics' that result from their decisions. They aim to rectify this by suggesting a 'sustainability' principle that would sit alongside these other ethical principles, serving as a side-constraint that rules out certain allocation choices or as a distinct reason to be weighed in the decision-making calculus (or a reason to save or insure against negative dynamics).

I agree that the downstream effects of our allocation decisions matter, whether they concern the immediate benefits to particular individuals or our overall capacity to provide benefits to people in the future. This is an important point—one the authors make well. I am also willing to believe that 'health systems' do a poor job taking this—along with many other ethical considerations—into account in their operational principles. But, if we are doing ethics, I would have thought that ideas relating to 'sustainability' were already easily and better incorporated by extant ethical views.

When considering how the 1000 units ought to be distributed, it is plausible that one of the considerations that bears on the question is the utility (or net increase in well-being, etc) that will result from an allocation decision. If allocation A1 will generate

10million points of utility and allocation A2 will generate 100,000 points of utility, this is at least a consideration (although perhaps not a decisive one) in favour of A1. If we want to build in uncertainty, we can shift to an expected utility framework or talk in terms of expected cost–benefit analysis. We can call all of these broad outcome regarding ethical principles. Everyone should accept that these downstream outcome-related considerations matter, ethically, even if we reject consequentialist views that suggest that they are all that matter.

So, if healthcare systems are spending a ton of money on expensive new drugs that 'have very modest or very uncertain clinical effects'¹ or making allocation decisions regarding antibiotics that create negative effects through pollution and accompanied antibiotic resistance, these decisions will fare poorly by the lights of any broad outcome regarding ethical principle.

The authors seem to believe their sustainability principle is both better and easier to operationalise for health system decision-makers than a broad expected utility principle would be. I don't see why. And to the extent they simplify or restrict their sustainability principle to make it easier to operationalise, this leaves them open to criticisms—very much like the ones they raise here—that their principle ignores important ethical considerations.

Their sustainability principle states, 'if a resource allocation pattern at time t1 produces negative dynamic effects at time t2, this to some extent counts against this pattern at t1, and in favour of resource allocation patterns at t1 with no or weaker negative dynamic effects at t2'. They restrict the principle to 'negative dynamic effects' that are caused by 'a systemic mechanism'.¹

Why should only 'negative dynamic effects' matter? What if an allocation decision causes distinct negative and positive dynamic effects, but they are net positive? Surely, from their sustainability vantage point, this should count in favour of the allocation decision, but their principle would suggest otherwise.

Similarly, focusing on those negative effects that are caused by a systemic mechanism might make the evidentiary burden on decision-makers lower, but it also might result in noting significantly bad effects that are not caused by a systemic mechanism, although still being caused by the particular allocation decision.

When thinking about effects caused by an allocation decision, is there any principled

reason to limit our focus to health effects?² There is a powerful case to the contrary, which they seem to acknowledge, and perhaps agree with—but then we are already in a broader, and correspondingly more evidentially complex, situation.

Their principle focuses our attention on possible negative dynamic effects at a particular time t2 in the future. There are questions about how far out in the future time t2 can be, but there is also the question of why we should simply pick another static moment at which to assess effects, rather than taking a dynamic approach that considers all utility effects, or all effects until some relatively distant point, perhaps discounted for future uncertainty.

Finally, there are hard questions about how to think of what constitutes a negative dynamic effect. They characterise it as one in which a 'resource is gradually depleted or the needs for that resource gradually increase'.¹ But then allocation decisions that result in significantly longer life spans (along with attendant higher health costs as people live into advanced ages) would be causing negative dynamic effects. That cannot be right. Again, better to go broader in the effects that matter.

Munthe *et al.* seem concerned to offer ethical principles that can be employed by healthcare system decisionmakers. But to the extent that their principle is epistemically less demanding, it is also likely to be misleading, ethically, just as we would be misled if we did not consider relatively broad future effects of our allocation decisions at all. Better to use a broad outcome regarding principle that captures the full set of ethically relevant consequences more accurately than one that concentrates our attention on this narrow set of mechanistically caused negative dynamic effects.

If health system administrators and other medical professionals who are currently the 'decisionmakers' are not up to the epistemic task of doing a reasonable expected utility, cost–benefit analysis in thinking through different allocation decisions, then we should rethink who it is that is making these decisions. Broad cost–benefit analysis is a staple of modern policy-making.³ It is hardly the unique specialty of philosophers. If the current people are not up to the task, change the people, not the principles.

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