

ALLOCATION OF SCARCE RESOURCES IN HEALTH CARE: VALUES AND CONCEPTS

ALOCAÇÃO DE ESCASSOS RECURSOS NO CUIDADO DE SAÚDE: VALORES E CONCEITOS ASIGNACIÓN DE ESCASOS RECURSOS EN EL CUIDADO DE LA SALUD: VALORES Y CONCEPTOS

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KEYWORDS: Health. Health resources. Delivery of health care.

ABSTRACT: In many countries, a gap exists between the population's need for health care and available resources. These nations have attempted to eliminate or reduce the gap through such activities as improving efficiency and narrowing responsibilities. Since these measures have proven insufficient, decisions must be made regarding how to best use the scarce resources. The priority-setting and rationing processes involve key decisions in the sense that they have consequences for people's health and quality of life and they should therefore be rational and based on solid grounds. This means that the decisions involve three issues: facts, concepts and values. In this presentation the focus is on the conceptual and value issues. A basic ethical platform as a guide for decision-making will be presented. The ethical principles that constitute the platform contain central concepts like health care need, cost-effectiveness, health and goal. A short presentation of these concepts will be carried out. This will end with the concept of a goal and its importance for decision-making.

PALAVRAS-CHAVE: Saúde. Recursos em saúde. Assistência à saúde.

RESUMO: Em muitos países existe uma lacuna entre a necessidade da população por cuidado de saúde e os recursos disponíveis. Estas nações têm tentado eliminar ou reduzir a lacuna por meio de atividades como, por exemplo, o melhoramento da eficiência e a atribuição de responsabilidades. Uma vez que estas medidas têm sido provadas como insuficientes, as decisões devem ser tomadas levando em consideração o melhor uso dos escassos recursos. O estabelecimento de prioridades e o processo de racionalização envolvem decisões chave no sentido de que elas têm conseqüências para a saúde e a qualidade de vida da população e devem, deste modo, ser racionais e baseadas em fundamentos sólidos. Isto significa que as decisões envolvem três questões: fatos, conceitos e valores. Neste artigo, o foco é sobre as questões conceituais e valorativas. É apresentada uma plataforma ética básica como guia para a tomada de decisão. Os princípios éticos que constituem a plataforma incluem conceitos centrais, tais como, necessidade de cuidado de saúde, custo-efetividade, saúde e objetivo. Uma curta apresentação destes conceitos é realizada e é finalizada com o conceito de objetivo e sua importância para a tomada de decisão.

PALABRAS CLAVE: Salud. Recursos en salud. Prestación de atención de salud.

RESUMEN: En muchos países existe un vacío entre la necesidad de cuidados de salud de la población y los recursos disponibles para realizar esos cuidados. Esas naciones han procurado eliminar o reducir el vacío existente a través de la realización de actividades, como, por ejemplo: la mejoría de la eficacia y la atribución de responsabilidades. Puesto que esas medidas han probado que son insuficientes, las decisiones deben ser tomadas considerando el mejor uso de los escasos recursos. El establecimiento de prioridades y el proceso de racionalización implica decisiones claves, ya que ellas tienen consecuencias para la salud y la calidad de vida de la población, y por ello, deben ser racionales y basadas en argumentos sólidos. Eso significa que las decisiones a ser tomadas engloban tres cuestiones: hechos, conceptos y valores. En el presente artículo, el foco es sobre las cuestiones conceptuales y valorativas. Es presentada una plataforma ética básica que sirve como guía para la toma de decisiones. Los principios éticos que constituyen la plataforma contienen conceptos centrales, tales como: necesidad de cuidado de salud, costo-eficacia, salud y objetivo del cuidado de salud. Una breve presentación de esos conceptos es realizada, finalizando con el concepto de objetivo del cuidado de salud y su importancia para la toma de decisiones.

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INTRODUCTION

In many countries, a gap exists between the population's need for health care and available resources. These nations have attempted to eliminate or reduce the gap through such activities as improving efficiency and narrowing responsibilities. Since these measures have proven insufficient, decisions must be made regarding how to best use the scarce resources. No disagreement exists on this point, and the situation is not new; health care resources have always been scarce. What is new is that the situation of scarcity has been publicly acknowledged and that decisions on how to use the scarce resources, and the grounds for those decisions, have been made public. The decision-making process should be open, and may include the participation of citizens. The idea of citizen involvement is sometimes presented as empowerment of the public.¹

The priority-setting and rationing processes involve key decisions in the sense that they have consequences for people's health and quality of life. Because the decisions sometimes concern life and death, we want them to be rational and based on solid grounds. This means that we want decisions to be based on facts, concerning, for instance, health care needs or the relative effectiveness of different treatments. But not every fact will do. The choice of facts should be rational. If, for instance, we set priorities in accordance with health care needs, facts about these needs are essential – but before we have a clear understanding of the concept of health care need, we do not know exactly which facts. Whether we should focus on health care needs or on other things depends on the ethical principles that guide the priority-decision. Health care needs only become interesting if the principle of need guides the priority-decision.

In other words, three types of issues are involved here: issues about facts, concepts, and values. A hierarchy exists between these categories. We do not know what facts to look for until we have an answer to the conceptual issue, and we do not know what concepts to use before we have an answer to the value issue.

Different views exist on what should constitute a value base for decisions concerning the allocation of health care. This essay will not include any attempt to give an overview of these views. Only one example of a value base will be used for illustration. The essay will mainly concern

conceptual issues. It begins with an analysis of the concepts of allocation, prioritization, and rationing, and proceeds with a presentation of the value base that was implemented through the Swedish Health Care Act. A central principle in this value base is need. In order to understand the need principle, we must analyze the concept of health care need. This analysis leads to the concept of a goal and to the question of the goal of health care. As the goal of health care basically is a value issue, a value base that includes a principle of need must also include a principle for choosing the goal of health care.

THE CONCEPTS OF PRIORITY-SETTING, AND RATIONING

We can distinguish between two situations of scarcity in health care. In the first situation, we can meet all needs for health care but not at the same time; the needs must be met in a particular order. This is a common and unavoidable situation. All patients in the waiting room, for instance, cannot be treated at the same time. In the second situation, all needs cannot be met within a set time span. In principle, we can in such a situation choose between the following alternatives: A) meet no needs at all; B) meet every need but only to some extent; C) meet some needs optimally, and others not at all; D) meet some needs optimally, and others only to some extent; E) meet some needs only to some extent, and others not at all; F) meet some needs optimally, some needs to some extent, and others not at all; G) meet every need only to a partial extent, but some needs to a larger extent than others; H) meet some needs optimally, some needs to a large extent, and others to a small extent.

These activities are sometimes called “rationing” and sometimes “setting of priorities”. Different people use the three terms in different meanings, under different circumstances, to cover one or more of the items. A consistent conceptual structure will reduce the risk for confusion.

The concept of prioritization

To prioritize always means prioritization in accordance with something. We may, for instance, set priorities in health care in accordance with health care needs. But we may also prioritize between something; for instance, between treatments, patients, clinics, or health care centers. What we set

our prioritization in accordance with is in some cases identical with what we prioritize between. In many cases, when we prioritize between health care needs, we do so in accordance with health care need. In other circumstances, we prioritize in accordance with something different from what we prioritize between. We may, for instance, prioritize between different groups of patients in accordance with health care needs. What we set priorities in accordance with will be called the prioritizing category. In those cases where we set priorities in accordance with health care needs, health care need constitutes the prioritizing category.

To set priority implies making a conscious decision or choice. Not every choice in health care, however, should count as a choice of priority. The priority-decision concerns a choice between considered alternatives. We cannot say that we have chosen alternative A over alternative B if we have never considered B; the alternatives must belong to the same prioritizing category. A decision to allocate a health care resource to a person in need but not to a person not in need should not count as a priority-setting decision. Likewise, to choose an effective treatment instead of a non-effective treatment should not be considered as a priority-setting decision. Non-effective treatments do not belong to the prioritizing category.

The prioritizing category, determined by the priority-setting principle, is an essential element in the concept of prioritization. For example, if the setting of priority in health care is guided by the principle of need, we should set priority in accordance with health care need, and health care need constitutes the prioritizing category.

Setting of priorities normally involves a combination of choices or decisions. Setting of priorities in accordance with needs means that we consciously create an order between the needs. This is one essential component. We are normally not content with ordering the needs, however. We want to take further measures. In the first situation of scarcity mentioned above, we could meet all needs, but not at the same time. Setting of priorities in such a situation includes the decision to rank needs in a particular order – and to optimally meet all of them in the order of ranking. In other words, a priority-decision may involve more than one choice and, therefore, a set of sub-decisions.

In the second situation of scarcity, all needs cannot be optimally met within a set time span.

Eight different ways of handling such a situation were mentioned above. Only two of them do not involve prioritization: items one and two. The process in item three involves three sub-decisions: how to rank the needs; where to draw the line in the order of ranking; and how to treat the needs on either side of that line. The three sub-decisions together constitute a priority-decision. We may compare this process with the process in item four, which includes sub-decisions concerning ranking and where to draw the line, in addition to a sub-decision concerning the extent to which needs below the line should be met. The first two decisions are sub-decisions concerning priority-setting, while the third decision – to what extent the needs below the line should be met – is not a priority-setting decision. This sub-decision, I will argue later, should be considered as rationing.

The reasoning above illustrates that priority-setting decisions concern the following kinds of sub-decisions: how to rank the needs, where to draw the line in the order of ranking, and whether the needs should be optimally met at all on their respective side of the line. The sub-decision of how to rank needs is an essential component in priority-setting. A choice that does not include such a sub-decision should not be considered as priority-setting. The other two sub-decisions have only a contingent status. They may or may not be combined with the first kind of sub-decision in a priority-decision, and they can only be considered as sub-decisions concerning priority-setting in combination with the first sub-decision. This implies that we can have several kinds of priority-decisions, depending on what kinds of sub-decisions are involved.

One priority-decision involves a sub-decision to rank the needs and a sub-decision to meet all of them optimally in the order of ranking. This process is used in the first situation of scarcity, where we can meet all needs but not at the same time. A second priority-decision involves a sub-decision to rank the needs and a sub-decision to draw a line in the order of ranking. A third priority-decision involves a sub-decision to rank needs, a sub-decision to draw a line in the order of ranking, and a sub-decision to meet the needs on one side of the line optimally and the needs on the other side not at all. The sub-decisions are integrated in practice, and the order between them may sometimes be different. The third priority-decision can, for instance, start with the sub-decision not to meet all needs.

That reasoning leads to the following conclusion. In order for a decision concerning a choice between X and Y to count as a priority-setting decision, three conditions must be fulfilled: A) X and Y must both be considered; B) X and Y must both belong to the same priority category; and C) the decision must imply the creation of an order between X and Y.

The three conditions together constitute a sufficient condition for a decision to count as priority-setting. Besides, the concept of prioritization characteristically includes a value component. What constitutes the prioritizing category is normally connected to something that is positively valued. To set priority is in general considered as something negative. The alternatives that we are forced to choose between all represent, in some sense, something positive. We usually do not consider it as setting of priority when we choose between only negative alternatives.

We may also make a distinction between active and passive prioritization. We have so far been speaking only of active prioritization: the making of conscious decisions in advance of implementation. Passive prioritization, on the other hand, concerns a decision to accept the end-state of an allocation process, implying that one instance is favored against another. But the acceptance must be voluntary in the sense that the person who is accepting has the power to change the end-state. A standard case of passive prioritization would be when a person external to the decision-making process decides not to attempt to make a change in the end-state. The process that produced the end-state may be result-oriented or end-state-oriented; it may imply that some petitioners will receive nothing while others receive what they need.

The concept of rationing

An alternative way of dealing with a situation of scarcity where everybody cannot get what they want or need is to give a small portion to all; their needs will not be optimally met. Intentional restriction is the essence of rationing. In the second situation of scarcity, where all needs cannot be optimally met within a designated time span, rationing would be a possibility. The term “rationing” will in this essay be used to refer to a decision to not meet the need for health care optimally. Such decisions are included in the processes illustrated by items two, four, five, six, seven, and eight.

The meaning of “optimally” is crucial in the stipulated sense of “rationing” presented here. That a need is optimally met can mean several things. It can mean that: 1) the goal of need is achieved to an optimal level; 2) the goal is achieved within a set time span; 3) the goal is achieved with some degree of security; 4) the goal is achieved with few secondary effects; or 5) the goal is achieved at a reasonable price.

Rationing of health care in accordance with need can thus meet one or more of these five conditions. We can, for instance, ration health care by extending the waiting-time for treatment or by using cheaper drugs with more secondary effects. We can also ration health care by setting a high price on some treatments, with the consequence that not all people can afford those treatments.² What we primarily think of when we speak about rationing is, perhaps, restriction along the first dimension. In such cases, the goal of need will not be optimally achieved (the phrases “the goal of need” and “optimally achieved” will be explained when we deal with the concept of health care need). To restrict rehabilitation activities would be one example of not meeting a need for health care optimally.

We can combine priority-setting and rationing in the sense that the process of rationing involves priority-decisions, a point that is illustrated by items four through eight. A rationing process involving the decision to meet some needs optimally and others only to a partial extent (item four) may be preceded by the priority-decisions of how to rank needs and where to draw the line.

We can distinguish between two main kinds of rationing processes. The first deals with pure rationing, where no priority-decisions are involved. It includes the decision not to meet all of the needs optimally and the decision concerning the extent to which the needs should be met (item two). The second kind of rationing process involves priority-decisions. These decisions concern how to rank needs and where to draw the line (items four through eight).

We can consider priority-setting and rationing on more than one level. So far, we have been concerned with the individual level. The individuals' needs for health care are ranked and decided on. But we can also speak of a population's need for health care, which then means the sum of the individuals' needs. A process of setting priorities on this level may mean that some needs in the population are not met at all. Another way to describe this process

is to say that the population's needs have not been optimally met, and not meeting needs optimally is a kind of rationing. In other words, a process that is considered as priority-setting on one level may be considered as rationing on another level.

THE VALUE ISSUE: AN EXAMPLE OF A VALUE BASE

The choice of a value base for decisions of allocation is crucial. The value base determines the answers to subsequent issues concerning concepts and facts. In addition, it determines what other issues will become interesting. In order to illustrate the significance of the choice of value base, I will in this essay use an example from Sweden.

In 1992, the Swedish government decided to appoint a parliamentary commission with the task of discussing the role of health services in the welfare society and to highlight the basic ethical principles by which prioritization ought to be guided. The findings of the commission on the setting of priorities are now incorporated in the Swedish Health Care Act.³

The value platform for setting of priorities in health care was presented in terms of three ethical principles: the principle of human dignity, the principle of need and solidarity, and the principle of cost-efficiency.

The principle of human dignity is based on an idea of universal human equality. According to this principle, human beings have equal worth and an equal right to respect and dignity. Human dignity is not geared to people's personal qualities or functions in the community, such as age, ability, social status, income, health status, etc.

The principle of need and solidarity asserts that resources should first be committed to those fields, activities, or individuals where needs are greatest. This principle implies that most of the health care resources should be given to those who are most in need. The greatness of need should then be assessed in terms of the severity of the injury or illness.

Solidarity means, in part, an effort to equalize the outcome of care as far as possible, at the same time devoting special consideration to the needs of the weakest. Some people are not aware of their human dignity or have less chance than others to make their voices heard; children, senile patients, the unconscious, and the confused, for example, or

persons with serious mental disorders. As a risk exists that these needs will not be communicated, the idea of solidarity demands particular attention.

The principle of cost-efficiency means that we should try to get as much good as possible out of the scarce resources in an individual case. This may imply, for instance, that we should choose the most cost-efficient treatment when we have a choice. According to the commission, however, we should not be dogmatic here – we should “aim for a reasonable relation between cost and effect”.

The report delineates which other principles we are not allowed to consider in this context. The commission rejects the use of the utility-principle – the idea that scarce resources should be used in a way that maximizes the utility of society. It also rejects the principles of lottery, demand, and autonomy. Nor are we allowed to consider things like age, self-inflicted injuries, economic ability, or social functioning. The commission emphasizes the importance of paying particular attention to the weakest people, those who cannot themselves demand health care.

Critics have turned against the ranking-order of the principles in that platform.⁴ The commission ranked the principle of need before the principle of cost-efficiency in a lexical order. This means that the size of the need should determine who should be treated when not all can be treated. The size of the need should be determined by the severity of the illness or injury.

This ranking-order of the principles appears quite reasonable in most circumstances. Normally, it is better to give the scarce resources to those who are most ill than to give them to those who can benefit most from the resources, when these two considerations do not coincide. The ranking-order can also have the effect that a seriously ill person, for whom we can do little, is ranked before a slightly less ill person whom we can restore to a normal life.

This is unacceptable. The absolute character of the ranking-order, which does not allow exceptions, is unfortunate.

The three principles have different guiding functions in the value base. The principle of human dignity is a restrictive principle. It constitutes a framework beyond which we are not allowed to pass, and tells us what should not guide our decisions. The other two principles are active ones: They tell us what should guide our decisions. But in order to give guidance, the principles must be

interpreted. We will in this essay concentrate on the principle of need. The crucial thing for a reasonable interpretation is the analysis of the concept of health care need.

THE CONCEPT OF A GOAL

A few fundamental issues concerning the conditions for the setting of goals have to be addressed. One issue concerns the concept of a goal: What do we refer to when we are using the term “goal?” Do we, for instance, refer to something that is wanted, or do we refer to something that will be achieved? When we speak about the goal of health care, do we then mean a goal that is or should be chosen by health professionals?

A second issue concerns the different components of a goal-structure. A tendency exists, when discussing goals in general, to consider a goal as an altogether single entity. This may be acceptable in some circumstances, but it is quite unsatisfactory when discussing the goal(s) of a complex enterprise like health care. In such a case not just one single goal exists, but a structure of goals normally organized in a hierarchy.

A third issue concerns the most important dimensions of a goal. The setting of a goal implies the making of decisions based on three dimensions – quality, quantity, and temporal considerations. The quality dimension concerns what is to be attained; the quantity dimension concerns how much of the specified quality is to be attained; and the temporal dimension concerns when the goal is to be attained.

All these aspects and dimensions of a goal can be combined in different ways. A decision concerning which combinations are of interest is vital to the discussion of health care or its goals. Exploring these issues can help us create a conceptual platform for a discussion of the goals of health care.

The term “goal” is often used to designate a state considered to be an end of a sequence of events. The events may be caused by actions or by natural processes. In order for a state to count as a goal, it must be related in some way to an attainment. It must exist before its attainment: It must be anticipated or determined in advance. This is possible in different ways, and it can be helpful to distinguish between different types of goals.⁵

A goal can be a state that someone wants or wishes to attain. Most people set some goals in life concerning things like family, education, and occu-

pation. But goals are also set by groups of people, for instance different professionals. We can also find a desired goal in health policy documents of different kinds. Public participation in health, a regional policy document in Sweden suggests, should constitute the goal for health-promotion in the region. According to the Swedish Public Health Act, good health for the whole population should be the goal of the health care system. Both these goals are politically chosen; they may be called desired goals.

But a goal may also be something that ought to be attained. “Ought” can be used in different senses: ethical, legal, rational, etc. This type of goal may be called a normative goal.

Goal *versus* ideal

Not everything that is wanted or wished for can be attained. To call something that is wanted but cannot plausibly be attained an ideal is a reasonable idea. Plausibility then has a key function within this idea: It serves as a sort of line of demarcation between what end-state can plausibly be considered as a goal and what end-state cannot. We have a goal when the end-state can be attained with some degree of plausibility, and we have an ideal when the end-state can be attained with a low degree of plausibility. When the plausibility of attaining the end-state is extremely low or nonexistent, we have a utopian ideal or a vision. The World Health Organization’s often-cited definition of the concept of health is a good example of an ideal: *la santé est un état de complet bien-être physique, mental et social et ne consiste pas seulement en une absence de maladie ou d’infirmié.*⁶

A goal-structure as a hierarchy

We can try to attain a goal for different reasons. We may try to attain a goal for its sake, or for the sake of another goal. Sometimes a longer sequence of goals exists. This sequence can be organized as a hierarchy. A goal we try to attain for its sake will be called a basic goal; a goal we try to attain for the sake of another goal will be called an instrumental goal.

We can illustrate the relation between instrumental and basic goals by saying that we achieve a basic goal by achieving the instrumental goal. For example, we can improve a patient’s quality of life by comforting him or her, and we can comfort the patient by sitting by the bed and

talking to him or her. Talking to the person and giving comfort are here instrumental goals for the basic goal of quality of life.

Different kinds of instrumental goals exist. Two kinds are of particular interest here: operational goals and sub-goals. The difference between these two instrumental goals is that when an operational goal is attained, no further action is needed on the part of the agent (a single person or a group of persons) in order to attain the basic goal. In the example just mentioned, sitting by the bed and talking to the person gives comfort that in turn improves the quality of life. Comforting the person is here an operational goal for the basic goal of improvement in quality of life.

The other type of instrumental goal is a sub-goal. Such a goal is only a step you take toward the basic goal; further steps are needed from you in order to reach the basic goal. For example, in order to be able to talk to the person, you must get in contact with him or her. You may have to sit by the bed. Sitting by the bed is then a sub-goal for the basic goal of improvement in quality of life, because it is insufficient in this case for improving quality of life. Further actions are needed – you must also talk to the patient.

The operational goal

When an operational goal is attained, the agent need not carry out any further action in order to attain the basic goal. Further actions, carried out by other people, may or may not be needed. We therefore have two kinds of operational goals. Attaining the first kind of operational goal means that no further action is needed on the part of anyone in order to attain the basic goal. The intake of a painkiller is an example of this kind of operational goal: no further action is needed for attaining alleviation when this operational goal is attained.

Attaining the second kind of operational goal means that further action is needed on the part of some other agent than the original agent. Perhaps most operational goals in health care are of the second kind. Restoring health, for instance, normally involves several professions, each of which has its operational goal. In such cases, it is not sufficient that only one operational goal is attained in order to attain the basic goal; the operational goal of every profession involved must be attained. A particular profession may in some circumstances have more

than one operational goal. These goals are in such circumstances organized in a sequence. Suppose that a sequence consists of a basic goal and two operational goals. The basic goal is then attained by attaining the operational goal closest to the basic goal, which in turn is attained by attaining the first operational goal in the sequence. It is sufficient for the agent to attain the first goal in the sequence in order to attain its part of the basic goal.

The sub-goal

The characteristic of an operational goal, then, is that when this goal is attained, no further action is needed on the part of the agent in order to attain the basic goal. Sometimes, however, it is insufficient for an agent to attain a state in order to attain the basic goal: Further action is needed on the part of the agent. Such a state will be called a sub-goal. Buying a painkiller at the chemist's is an example of a sub-goal, as further action is required of the agent in order to attain alleviation.

The domain of the enterprise

The process of curing and caring may be directed by an action-plan. Such a plan may involve sub-goals and operational goals in addition to the basic goal. It is possible to describe the processes in terms of the goal-structure. In order to provide a complete description, a further item in the goal-structure must be considered – the domain of the enterprise.

A domain is related in a way to a goal-structure. It concerns the type of action to be employed in achieving the goal. A simple way of describing the relation between domain and goal-structure is to take an example from a country's defense system. The air force, the army and the navy all have the same basic goal – a free country. But they have different domains and different operational goals. The air force will defend the country by actions performed in the air, the army by actions performed on the ground and the navy by actions performed at sea. Their special competence determines which area it is rational to operate in.

The domains of different professionals involved in health work, broadly seen, may be determined, in the same way as in the example above, by a rational application of their competence. The politician, the health-promotion officer, and

professionals at the hospital, to name three, may all have the quality of life of the individual as the basic goal of their actions. But as their competences differ, it is rational for them to focus on different aspects of this goal. For example, the politician may reduce (or create conditions for a reduction of) unemployment; the health-promotion officer may educate people about health risks; and the health care professionals may cure diseases. Although the different professions have the same basic goal, they work in different domains and therefore have different operational goals.

The goal-structure exemplified

Consider the following items as possible goals of health care: the controlling of disease, absence of disease, health, and quality of life. Insofar as the concepts of disease, health, and quality of life are defined in a reasonable way, they denote different states. When health, for instance, is defined in terms of ability to realize vital goals, the state denoted by “health” is different from the state denoted by “absence of disease”. And if the phrase “quality of life” denotes a state that constitutes or is part of the good life, health is not identical to quality of life, but a condition for it.

Three of the items, although they involve different states, can simultaneously be considered as goals of health care, provided that they are parts of a goal-structure. Quality of life is then the basic goal of health care, while health is an operational goal. By attaining the health of the individual, health care has done its part in order for the individual to attain quality of life. If the individual cannot attain a reasonable degree of quality of life on his or her own, other professions or institutions may provide help. Health care attains the operational goal of health, in turn, by attaining the other operational goal – absence of disease. In those circumstances where a contribution from another enterprise is needed in order to attain health, medicine has done its part by attaining the operational goal of absence of disease.

What is the role of “the controlling of disease” mentioned above? It is not a goal of health care, but falls within the domain of health care because it concerns how the operational goals are attained. In the simplified sketch above, health care attains the operational goals by fighting diseases. In other words, the domain of health care, as exemplified here, is disease control.

What, how much, and when?

Irrespective of which place a goal has in a goal-structure, it can be considered in three dimensions – the quality, quantity, and temporal dimensions. The quality dimension concerns what is to be attained. This dimension has dominated in the descriptions of the goals in the examples above. When such suggestions as absence of disease, health, and quality of life have been placed in a goal-structure, only the quality dimension of the goal has been presented. The quality dimension is the primary one because the other two dimensions cannot be determined before we settle the question of what is to be attained.

The three dimensions can be combined in different ways. The quality dimension is the primary one, and an entity within this dimension may be kept constant in relation to the other dimensions. But a specification on the quantity dimension may influence the specification on the temporal dimension, and vice versa. For example, if we want to attain a goal and if we specify the temporal dimension, we must then specify the quantity dimension in such a way that the goal can plausibly be attained. If a specified amount of a state cannot plausibly be attained within a specified time, this specified state is not a goal; it is an ideal.

The goal of health care

Let us return to the issue of health care need. A health care need is a particular need. According to the basic formula of need, health care is needed insofar as it is necessary for realizing a goal. The crucial question is then what goal would be realized by satisfying a health care need.

This goal cannot be discovered. The goal has to be chosen; a decision has to be made. But the decision need not be arbitrary. It may be based on a rational approach related to the purpose of the whole health care system. For instance, if good health is the goal of the health care system and if the system should be determined only by the needs of the population, it would be quite irrational not to choose health as the goal.

But health is not significant in itself. It is significant because it contributes to people’s quality of life. I therefore suggest that quality of life is the basic goal of health care, and health is then an operational goal of health care. But in order to achieve this goal, it may be necessary to achieve other goals. These other goals would then, in turn, be operational goals for health.

THE CONCEPT OF HEALTH CARE NEED

We can now approach the concept of need for health care. According to the general formula, a need for health care exists when: 1) a gap exists between a person's actual state and a goal of health care; 2) and health care is necessary in order to eliminate the gap.

This leads to a model for assessment of need for health care.⁷ The concept of need has three fundamental components: the actual state, the goal of need, and the object of need. Information about these components is necessary and sufficient for an assessment of a need. The primary element of this model, then, is obtaining this information. This task may be performed in three stages: 1) determining the actual state; 2) determining the goal of need; 3) determining the object of need.

While the order of the first two steps might be reversed, the third step cannot be carried out before the first and the second are finished.

The goal of health care need

We cannot always reach full achievement of a goal. A decision is therefore necessary concerning what degree of achievement should constitute the goal of health care need. That some state of achievement constitutes the goal of need means that when this state is realized, the need is satisfied, and no further action is required. The state of achievement that constitutes the goal of need will be called an optimal state. To meet a need for health care optimally means achievement of this state.

A need is basically a gap between the actual state and a goal. Satisfying a need therefore means the elimination of this gap. The need is eliminated when the gap is eliminated.

We can eliminate a need in more than one way. We can eliminate the gap by manipulating the actual state, changing the goal, or both. Our first thought is to manipulate the actual state – to give nursing care. In principle, it is possible to eliminate a need by choosing a low state of satisfaction of needs. It is possible then, but hardly acceptable, to dramatically cut down the individual's need for health care by using a concept of need that mirrors low ambitions with respect to the goal. But it is also possible to do just the opposite. High ambitions could be established with respect to the goal, which would mean an increased amount of need for health care.

How should we determine the appropriate degree of achievement? No algorithm exists for this. The goal has to be chosen, and the choice is not only a matter of empirical investigation but also – and mainly – a matter of evaluation. The choice may be dependent upon some basic evaluation on the part of the entity that does the choosing. This implies that an issue at the second stage may be considered key for the whole assessment procedure.⁸ Who will have a dominating influence on the decisions? Whose values should determine the choice of the goal for health care need?

The object of health care need

Determining the object of health care need at the third stage concerns the services needed – the level and type of health care necessary for realizing the goal. The central question at this stage is whether health care is necessary in order to eliminate the gap between the actual state and the goal. Answering this question requires the competence of professionals. The determination at this stage is to a great extent an issue for health professionals, but not exclusively.

The situation varies with the number of treatments available for a specific purpose. Only one treatment may be available, or none at all. In many cases, however, a choice exists, including the option of renouncing treatment altogether. In making such a choice, professional considerations are not the only valid ones. Other values, in particular ethical ones, must play a central part.

Need assessment and economic considerations

Another interesting, and more general, issue concerns what factors should be allowed to influence the decision concerning the goal. Economic considerations constitute one of the most interesting factors here; the level of knowledge in health care is another one. It is tempting to say that economic factors should influence the decision. For instance, if an individual or entity can afford only a partial degree of achievement of the goal, it may seem pointless to choose a higher degree as the goal of health care need.

But to adopt this attitude would be to make a mistake. We must here distinguish between (1) the circumstance that a need exists, and (2) the choice of whether this need can or should be met. We err

when we argue that a need exists only if it can or should be satisfied; the second condition should not be put as a necessary condition for the first. We make no contradiction when we say: "a need (for health care) exists, but this need cannot be satisfied". A thirsty person in the desert needs water even if there is no water within reach, and a starving person needs food even if he or she cannot afford it.

The existence of a need is altogether independent of whether we can afford to meet the need. Economic considerations should not therefore influence the identification of needs. They may only influence the decision as to whether the need should be satisfied, or with what treatment it should be satisfied.

CONCLUSION

If we adopt an ethical platform as a guideline for setting of priorities in health care, some concepts come into focus. In our example, the concept of health care need became more interesting in this light. The analysis of this concept led to the concept of a goal and to the argument that an understanding of the goal of health care need is necessary for an understanding of the concept of health care need. The goal of health care need, in turn, must be related to the goal of health care if the principle of need is to be used as a guideline for setting of priorities in health care. This means that the concept of health care need cannot be adequately analyzed until we have a clear idea of the goal(s) of health care.

Insofar as we want ethics to guide our decisions concerning setting of priorities in health care, ethics should guide our choice of the goal of health care. The approach I suggest here is built on the following idea: human beings have some duties toward each other. A variety of actions may fulfill these duties. Some are quite simple and require only the effort of one person, while others are more complex and require the cooperation of several persons. Such cooperation is sometimes manifested in enterprises. The purpose of creating an enterprise may be based,

then, on some duties toward human beings. The goal of the enterprise is to contribute to the fulfillment of these duties. The purpose of creating the enterprise determines its goal.

We must complement an ethical platform like the example we have been discussing with an ethical principle for the choice of the goal of health care. None of the three principles considered here can fulfill this task. This analysis also illustrates the necessity of interaction between an ethical analysis and a conceptual analysis. In this case, the suggested ethical platform leads to concepts that, upon analysis, lead us back to a revision of the ethical platform.

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