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Rationing Health Care and the Role of the 'Acute Principle'

Abstract:
In several works, Hartmut Kliemt has developed an original account on the necessity of rationing health care and on how a rationing policy should be carried out. While I agree on several important points of that view, there is one important aspect of his account that I do not find plausible: his claim that the so-called 'acute principle' (a principle that gives absolute preeminence to rescuing identified lives from dying) should be one of the basic criteria to carry out a rationing policy in a liberal state. After explaining Kliemt's view on rationing health care and, more specifically, the foundations of the acute principle, I argue that the acute principle is not supported by our basic moral intuitions. I then apply the previous argument to the case of rationing, arguing for the necessity of a compromise among intuitions supporting the acute principle and other moral intuitions. Finally, I try to show that a feasible system of public health care services is conceivable. In doing so, I make use, with some relevant modifications, of Kliemt's own ideas.

1. Introduction

In several works, Hartmut Kliemt has developed an original account on the necessity of rationing health care and on how a rationing policy should be carried out.[1] I agree on several important points of that view. First, I share Kliemt's point that rationing health care should not be considered taboo: state expenditures in health care should be (or will eventually have to be) rationed. I also think, like him, that rationing should be done according to public, transparent criteria. Moreover, those criteria should be consistent with the basic moral intuitions underlying the liberal, constitutional state. There is, however, one important aspect of his account that I do not find plausible, and in this paper I would like to focus on that point. I mean his claim that the so-called 'acute principle' (a principle that gives absolute preeminence to rescuing identified lives from dying) should be one of the basic criteria to carry out a rationing policy in a liberal state. In *section 2*, I explain Kliemt's view on rationing health care and, more specifically, the foundations of the acute principle. Then I argue that the acute principle is not supported by our basic moral intuitions (*section 3*). In *section 4*,

[1] Kliemt has written extensively on this issue. In this paper I consider only his most recent contributions (see References).

I apply the previous argument to the case of rationing, arguing for the necessity of a compromise among intuitions supporting the acute principle and other moral intuitions. In the *final section*, I try to show that a feasible system of public health care services is conceivable. In doing so, I make use, with some relevant modifications, of Kliemt's own ideas.

2.

Kliemt's starting point is that rationing health care is unavoidable, given the increasing costs of (meaningful) health care technology. Sooner or later, the state-financed spending in health will have to be cut down (Kliemt 2007, 4; 2006c, 45–50). If this is true, it is better to proceed according to a public, transparent, and morally justified criterion rather than according to the private, decentralized criteria of physicians (Kliemt 2007, 10–11; 2006c, 56–58).

In order to discover an adequate criterion for rationing, Kliemt suggests that we should change our basic perspective about why the state is morally required to finance health care services. According to the common view, the reason is straightforward: the state finances those services to fulfill the society's fundamental interest on health. Assuming some essential tenets of a liberal perspective of society, Kliemt claims that the main reason is different: the upholding of the constitutional state (Kliemt 2006a, 373–376).[2]

What is the connection between the constitutional state and the warranty that the state will support some health care services? According to Kliemt, the connection is symbolic. We, as members of a constitutional state, do not want to see people die on the street, if we can collectively avoid it.[3] In the case of health care, this symbolic role of the state is supported by what Kliemt calls 'acute principle' (*Akutprinzip*): "the more acute and immediate a life threat is, the higher the social duties of solidarity" (Kliemt 2006a, 370; hereafter all translations are my own). Kliemt claims that the acute principle is based on our common-sense distinction between identified (or concrete) lives and statistical lives: "a concrete endangered life should not be traded off against other, abstract lives" (Kliemt 2006a, 370). The principle implies two things. It implies, first, that measures aimed to save concrete endangered lives have preeminence over measures aimed to save statistical endangered lives. Second, it implies that measures aimed to save concrete endangered lives have preeminence over measures to save persons (not from death but) from non lethal illness or disability. Notice that persons undergoing a risk of non-lethal illness can also be concrete: if the state does not finance the diabetes treatment of a poor patient, such omission affects a concrete, identified person. However, according to Kliemt, that would not transgress

[2] Kliemt uses the term "Rechtsstaat", which embraces both the idea of the constitutional, liberal state and the idea of the rule of law. Hereafter I will use the term 'constitutional state', 'liberal democracy', and 'rule of law' more or less freely and interchangeable.

[3] In Kliemt 1993 he argues that a constitutional state and the rule of law is compatible with a (minimal) welfare state.

the acute principle. The acute principle is transgressed only when the state does not finance actions oriented to save concrete persons from imminent death.

In Kliemt's view, the acute principle provides a useful guide to establish a plausible policy of rationing in health care. According to Kliemt, "acute and transparency principles are two essential viewpoints of political ethics, which can serve as guiding viewpoints" (Kliemt 2007, 15; see also 2006b, 41). More specifically, "the acute principle offers a general answer to the question concerning the distinction between what we should consider as basic provision and supplementary provision" (Kliemt 2006b, 42). Basic health services, guaranteed by the state, should be assigned to fulfill the moral demand of rescuing people from imminent death.

Before asking more carefully about the connection between the acute principle and the rule of law, it must be stressed that, according to Kliemt, the acute principle is not sufficient. On the one hand, other conditions are necessary, for example, transparency. On the other, even if we follow the acute principle, further rationing measures may well be necessary in the future. For example, dialysis is a life-saving technology and should therefore be offered unconditionally, according to the acute principle. However, it may well be the case that dialysis (or other expensive) measures will have to be curtailed in the future, for instance, giving preeminence to younger patients over older ones (see Kliemt 2006a, 375; 2006b, 42).

The acute principle and the corresponding (and more abstract) principle of preeminence of identified lives over statistical lives are, in an important sense, irrational. Kliemt acknowledges this (Kliemt 2006a, 373), insofar as we take these principles as guiding a health care policy seeking the maximization of health in society. However, if our goal is not maximizing health but stabilizing or reinforcing the rule of law, then those principles may become rational.

Why does guaranteeing some health services according to the acute principle support the stability of the constitutional state? Kliemt is not quite clear on this point. The acceptance of the acute principle and the preeminence of identified over statistical lives, says Kliemt, is "universal" among citizens of west democracies (Kliemt 2006a, 369). This widespread view seems to be connected to the "acknowledgment of the preeminent value of individual life" (Kliemt 2006a, 374; see also 2007, 9).

One interpretation of Kliemt's view is that the acute principle reflects an agent-relative reason to rescue imminently endangered lives. There would be a deontological constraint against letting people die. A legitimate liberal state would be required to honor such individual (non-aggregative) right to be saved. In the same way as we are not allowed to kill one person to save others, the acute principle would claim that we cannot let one identified life die in order to save other, statistical, ones. The same agent-relative principle would forbid us to let one identified person die to prevent many (identified or statistical) persons from suffering a non-lethal illness.

However, this strong interpretation does not seem to be Kliemt's view. When he says that the reason to accept the acute principle is "symbolic" and that the

goal is the preservation of the constitutional state, what he is suggesting is this: Because most people (irrationally) endorse the acute principle, a state's not including a set of life-saving policies (among others, a health care policy for life-threatening conditions) would *appear* to those people as not respecting the intrinsic value of individual lives and, therefore, the stability of the constitutional state would be undermined. Kliemt's argument is therefore consequentialist, not deontological. This is not an objection in itself, but we should stress the fact that this argument founds the public approval of the acute principle on an *irrational* belief held by most individual people. It is not irrational to support the public enactment of the acute principle, but the argument is indirect: we are interested in the preservation of the constitutional state and, given the (irrational) beliefs of people, such enactment is instrumentally efficient to achieve that goal.

Kliemt's view sounds therefore somehow paradoxical, but it is not inconsistent. In an ideal world, it is irrational for any individual person to endorse the acute principle as a public policy. If her interest is to maximize her individual health, she should support a public policy oriented to maximize general health and not one guided by the acute principle. In the real world, a rational (more sophisticated) person would make the following two-steps argument: I am interested in maximizing my own health. But I am also interested in preserving the liberal, constitutional state. This interest is more important than the first one (among other reasons, because without a constitutional state I would not enjoy health care either). Given the irrational beliefs of most people, enacting a public policy that maximizes general health would erode the liberal, constitutional state. Therefore, I support a public policy guided by the acute principle.

Since the argument is consequentialist, the connection between the acute principle and the stability of the constitutional state must be an empirical, causal one. As such, it should be supported by empirical (statistical) evidence about the moral intuitions of ordinary people, about the connection between those moral intuitions and the stability of the constitutional state, and so on. Kliemt does not provide such kind of evidence. The discussion is therefore speculative. In the same speculative vein, I argue in the next section that the acute principle is not supported by our basic moral intuitions, including our moral intuition that resources should not be allocated in an extremely irrational way. We have, of course, strong intuitions in favor of saving people's lives, but we have also strong intuitions against letting people suffer significant diseases or impairments.

3.

Let us then consider to what extent the acute principle is supported by our moral intuitions. I understand here moral intuitions in the restrictive sense of those moral beliefs that normal citizens share, such that ignoring those beliefs might incline people to find the political system illegitimate and, therefore, erode the stability of the constitutional state. I assume that such intuitions, as Kliemt suggests, are related to the idea of the preeminence of the individual dignity

over aggregative considerations. However, I think our moral intuitions do not support an unqualified preeminence of the duty to rescue people from death. We have competing intuitions that require a more complex and nuanced picture. To show this, I will briefly consider some cases.

Let us first focus on diagnosis and prevention. Kliemt claims that "the consequent application of the acute principle implies, for example, that preventive medicine, as well as wide performed screening, should be eliminated from the list of measures to be guaranteed by the state" (Kliemt 2006b, 42). Kliemt manages to include vaccines (the most typical preventive medical measure) into the basic service-package by regarding them as public goods (Kliemt 2006a, 376). I will not dispute this point, although it is not entirely clear to me that vaccination can be classified as a public good in the full sense of the word.[4] Letting aside the case of vaccines, there is a wide range of diagnostic and preventive measures, which may well have legitimate preeminence over some life-rescuing ones. I will offer just one example. In developed countries, every newborn's blood is tested for at least two diseases: phenylketonuria (PKU) and neonatal hypothyroidism. These are genetic diseases, which are devastating without early diagnosis, but almost without consequences with early diagnosis and proper treatment. Kliemt's defense of the acute principle implies that this diagnostic practice, as well as the consequent treatment, should be outside the medical measures guaranteed by the state. That means that a poor person, without access to health insurance or economic means for diagnose and treatment of these diseases, would remain uncovered. Although these diseases produce serious health impairments, they are not imminently lethal. According to Kliemt, our moral intuitions prevent us from allowing a person die, but they do not prevent us from allowing a person undergoing these devastating harms. Although diagnosis and treatment of these conditions are not particularly expensive,[5] the sum of resources spent in all these kinds of measures could be applied in life-rescuing measures, increasing the number of identified people saved.

Now think on the paradoxical situation we are led to by accepting the acute principle as a guideline for health care spending. A poor person born with PKU will not be diagnosed and treated. However, after some years of suffering this devastating disease, when that person is about to die precisely from this condition,[6] all kinds of expensive medical means will be offered in order to save or prolong her life. Nobody can, after reflection, agree to that policy.

[4] At least it is not a public good in its pure form. Pure public goods generate a free-rider problem. In a free-rider situation the rational person prefers general defection to being the only cooperator (I prefer that everyone throws away garbage on the street to being the only one not doing so). This is because, if I am the only cooperator I do not obtain the good (I walk anyway on dirty streets). Instead, in the case of vaccines, the rational person would prefer being the only one getting vaccinated to general defection. I am not sure to what extent this difference amount to a proof that vaccination is not a public good, but I think it is a relevant difference.

[5] Both conditions are easily discovered with a blood test. The treatment is a strict diet in the case of PKU, and a replacement therapy with thyroxine in the case of neonatal hypothyroidism.

[6] PKU children have, among other things, increased risk of heart problems.

The same point could be extended to the treatment of many chronic diseases like diabetes or cancer. Citizens of a liberal democracy are not prepared to see how other citizens deteriorate just because they cannot afford a treatment against diabetes. In the case of health services during pregnancy and infancy this is still more apparent. We are not going to let a pregnant woman give birth at home, just because she cannot pay a hospital, even if giving birth at home is not life threatening (it is just more risky).

The point of these examples is not to prove that it is irrational to invest health care resources following the acute principle. The point is, rather, that we have competing intuitions. It is not obvious that our intuition for saving a person from imminent death will always overthrow our intuitions for preventing a person from having a non-lethal but serious disease. If this is the case, it is not clear that the acute principle is a good guide for rationing health care. In the next section, I show this more carefully.

4.

In this paper, I am neutral about the wider philosophical question of whether it is a function of the liberal state to strive for a general improvement of the health conditions of people. Whatever our position on this issue might be, it seems relatively indisputable that one essential function of a liberal state *is* the maintenance and reinforcement of the constitution and the rule of law. This is Kliemt's starting point and I assume it. I will now argue that, if my argument in the previous section is sound, a plausible account of rationing will have to find a compromise between competing intuitions. Let me mention three reasons for thinking that such a compromise is necessary.

As my previous argument shows, we have both the intuition that people in imminent risk of death should be saved and that people suffering non-trivial diseases should be diagnosed and treated. We do not want to see people dying on the street. But we neither want to see people suffering preventable illness on the street. It might be that the first intuition is stronger, but it is not infinitely stronger. At some point, we are ready to sacrifice life-rescuing spending in favor of illness-rescuing spending. Otherwise, the same kind of erosion of the liberal state will take place. I agree that failing to rescue people from death may undermine the stability of the rule of law. But failing to 'rescue' people from serious disease, or hunger, or homelessness may also have such destabilizing effect, even if those conditions are not imminently lethal. The balance of these destabilizing effects is not easy to make, but I see no reason to think that it will always tip in favor of life-rescuing measures.

A second point is connected to the fact that, as we have seen, the acute principle is collectively irrational, if each individual person wants to maximize her own health. Note that this is independent from the issue of rationing. Whether rationing is necessary or not, public health care expenditures can be invested more efficiently by following a compromise between life-rescuing measures and

illness-rescuing ones than by following the acute principle alone. From a certain threshold of irrationality on, irrationality becomes morally counterintuitive. If the state guarantees increasingly expensive life-saving treatments (like transplants, helicopters, etc.) but does not guarantee elementary diagnosis and treatment against infections, coronary conditions, diabetes, etc., at some point the situation would become so irrational that people, I speculate, will have a lapse of rationality and understand the plausibility of cutting some life-rescuing measures in favor of other measures that increase the number of statistic lives or the health condition of people.

A third reason to defend a compromise is the following. As we have seen, Kliemt acknowledges that the acute principle is (or will be) insufficient as a rationing criterion. Life-saving measures are also increasingly expensive and will eventually have to be cut down. Will this fact threaten the stability of the liberal state? It might be, to some extent. In any case, cutting down some *more* life-saving measures in order to preserve some meaningful health care services does not seem to be essentially more threatening. A sensible compromise between life-saving and illness-saving measures seem more stabilizing than an unqualified preeminence of life-saving measures, which will anyway have to be cut down as well.

All this suggests that, even if cutting down some life-rescuing measures might, to some degree, affect the stability of the rule of law, there is no reason to think that cutting down some diagnostic, preventive or curative measures will not have the same effect. To some degree, every rationing of health care (at least concerning serious conditions) will have a destabilizing effect. It seems that rationing according to a compromise between life-rescuing and illness-rescuing measures will more likely minimize such negative effect.

5.

Still, we might defend the acute principle by claiming that it offers at least a clear-cut distinction between basic and non-basic services. If we instead try to find a compromise between life-rescuing and illness-rescuing services, the list of guaranteed services would be indeterminate, and this would affect transparency and publicity. However, I think this is not the case. Let me finish by showing how a transparent system of guaranteed health care services could include services for life-threatening conditions as well as preventive measures and treatment of diseases. To do so, I will follow one of Kliemt's ideas, with some minor adjustments. Let me first quote Kliemt's proposal at length:

> "The obligation to have health insurance is abolished. Each citizen has the responsibility to ensure herself against health risks. Those uninsured must face the financial consequences of illness up to the point where they start to be covered by the social welfare. There is, therefore, over the social welfare (that anyway everyone has a right

> to), no public insurance against the financial risk of illness. However, there is a public guarantee that nobody in acute health or life emergency will be left unattended only because she cannot pay. If a citizen in an acute emergency situation can be helped with medical measures, the state is ready to advance funds for the respective services. There is a state guarantee for that. However, the state will require the devolution of the credit. Inasmuch as there are assets above the social welfare level, the citizen must pay, unless she has contracted an insurance for that payment." (Kliemt 2006a, 378)

Consider now the following modification of the system envisioned by Kliemt. Instead of guaranteeing services only for those conditions that are acute life or health emergencies, the state guarantees services of an average health insurance, which typically includes much more than emergency or life-saving measures (it includes prevention, diagnosis, and treatment both for acute and chronic diseases), and, at the same time, does not necessarily includes *every* possible life-saving measure.

Such a system would certainly be more expensive. But notice the two following points. First, the state will have to face those costs only in the case of people that are close to the level of social welfare. As Kliemt rightly says, everyone above that level will have a strong incentive to have a private health insurance, since she will by liable for those costs. Without health insurance, every non-poor person facing a non-trivial health problem would be financially ruined. Second, the health care budget would not increase indefinitely. That budget would be rationed according to the same criterion that an average non-poor individual citizen uses to choose a health insurance in the free market. That person will not necessarily buy a health insurance with access to *every* meaningful treatment and technology, including *every* life-saving measure. The premium would, at some point, start to be unbearable or unreasonable. In my model, the state would mimic a rational, average person and guarantee those services that such a person would have access to, given the current costs of medical technology. Moreover, I insist, those services would be offered for free only to those persons who have not contracted a health insurance and cannot afford the cost of treatment.

My purpose in suggesting this alternative is not to defend it as a plausible health care system. In fact, I have objections to it.[7] My purpose is just to show that there is a viable system of guaranties for health care that incorporates many (but not all possible) life-rescuing medical measures, as well as many (but not all possible) diagnostic and treatment measures for serious, non-lethal conditions. If my arguments in the previous section are plausible, there are reasons to think that such a system will be less detrimental to the stability of the liberal democracy than Kliemt's proposal.

[7] My objections are based on considerations of justice. But they are irrelevant for my purpose here.

References

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