APPLIED ETHICS FOR PROFESSIONALS PROGRAMME

RESEARCH REPORT

A discussion on the ethical complexities of micro-level decision-making in the South African private health insurance industry.

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INTRODUCTION

Health and, by extension, healthcare is accepted to be a valuable and important social good that is both a good in and of itself, as well as necessary "to the achievement of many other goals in one's life." (Landwehr 2013:298). Its fair distribution is therefore properly the subject of ethical concern and in the era of modern medicine where costs and potentially limitless treatments exceed available resources rationing healthcare has become a necessity. However, since rationing implies that not everyone's needs or preferences can be met, a fair and just way of rationing healthcare is a widely debated and controversial topic that, to date, remains unresolved. Where third-party private funding organisations[1] are tasked with these rationing responsibilities, the ethical complexities are compounded by perceived conflicts between the ethical frameworks that govern corporate organisations versus those that govern healthcare.

While in South Africa, Medical Schemes are bound by the regulatory requirements of the Medical Schemes Act no. 131 of 1998 (MSA) and may not be for-profit organisations, they do function as private organisations inasmuch as they operate without state subsidisation, are 'owned' by the members (as opposed to shareholders), and are subject to competitive market mechanisms. The tension between meeting the healthcare needs of each member fairly and stewardship of the funds of the cooperative scheme is particularly palpable in the context of micro-level decision-making for exceptional cases which fall outside the parameters of health plan contracts and are concerned with determining "who will receive particular scarce resources" (Beauchamp & Childress 2001:250), since these decisions can potentially compromise either of these obligations.

Given the apparent inability of normative theories to resolve the problem of how to ration healthcare fairly there has been a shift in thinking to considerations of procedural justice and a dominant model, Accountability for Reasonableness (AFR), has emerged as the favoured procedure for healthcare decision-making. This report will show that while AFR may be shown to be a legitimate and just process that can effectively frame decision-making and provide a platform to drive transparency and consistency,

[1] In South Africa there is a legal distinction between Medical Schemes (or Medical Aids) and Health Insurance. Medical Schemes are (by law) non-profit organisations and regulated by the Medical Schemes Act, whereas Health Insurance does not fall under the purview of the Medical Schemes Act. Health Insurance may be for-profit and is, currently, confined to offering risk insurance to cover gaps in healthcare expenditure that Medical Schemes are permitted to decline. This distinction seems unique to South Africa but is irrelevant for the purpose of this report, the use of 'Health Insurance' in the literature should be understood to include how South African Medical Schemes operate. 'Third-party payers', 'healthcare funders', HMOs (Healthcare Maintenance Organisations) and MCOs (Managed Care Organisations) are all similarly situated as private organisations that make funding decisions for healthcare remuneration outside of public funding mechanisms.

like most procedural accounts, it still does not guarantee that the outcomes it produces are necessarily fair or just. The report will show why health is an important social value and examine the key models and principles that dominate the rationing debate as well as why the conflict between healthcare ethics and organisational ethics create additional complexities that must be considered when making these funding decisions. An exposition of AFR will reveal that some of the conditions advocated in this account promote consistency and impartiality thereby ensuring a more fair approach to decision-making. However, sidestepping a commitment to any specific relevant ethical reasons and principles weakens its normative force and, even if all the conditions of AFR are satisfied, in the context of an unjust background, merely applying this procedural methodology to decision-making is inadequate as it cannot guarantee that the outcomes it produces are necessarily ethically just.

SECTION 1: THE VALUE AND DEFINITION OF HEALTH

Before considering the rationing models, some understanding of the relative importance, or value, of health is required to provide a basis for claiming that its fair allocation is properly the subject of ethical concern. Furthermore, a reasonable definition of health needs to be established to provide a justifiable explanation for why the ethical obligations of private healthcare funders are appropriately limited to interventions that actually promote or protect the health of all the participants in these cooperative schemes.

1.1 - The Value of Health

For most the value of health may simply be "important to the achievement of many other goals in one's life." (Landwehr 2013:298). While common intuitions underlie the belief that health is important and of special moral significance, the suggested rationales supporting these intuitions vary. Only luck egalitarians seem committed to the notion that there is nothing particularly special about health or the lack of it and that it is of no more moral significance than any other social good; they maintain that *any* disadvantages "based on reasons outside of the control of agents" (Segall 2010:348) are unjust and require intervention. As appealing as such an all-encompassing view may seem, it underestimates the significant impact poor health has on individuals and society, and why it therefore deserves special consideration.

Even though Rawls does not include health or healthcare in his list of primary social goods, Norman Daniels bases his argument on the importance of health within a Rawlsian framework of justice. There are two suggested rationales for Rawls' specific exclusion of healthcare distribution as an object of theoretical concern in his *Theory of Justice*; the first is that Rawls has an idealised view of the participants in the Original Position assuming "healthy and able-bodied persons as the norm." (Peter 2001:164), or, at least "healthy enough to be a fully cooperating member of society." (Sachs 2008:152). A second, more compelling possibility is the assumption that unequal distribution of health is natural, appears to be morally arbitrary, and therefore should not be considered unjust. Since Rawls's theory is specifically concerned with unjust distributions, the unequal, but not necessarily unjust distribution of health is therefore not considered the type of good that is subject to the Rawlsian distributional principles (Lutham 2006: online)[2]. Daniels' argument for proceeding within the Rawlsian tradition is that, although the distribution of health may not be unjust in this way, it does not follow that nothing should be done to "counter natural disadvantages induced by disease" (Daniels 1981:166); his central thesis on the value of health is that it is critical in order to achieve Fair Equality of Opportunity (FEO). He subscribes to a definition of health in terms of the biomedical conception of maintaining normal species functioning and further specifies the objective nature of healthcare needs and health as "determinant of the range of opportunity open to individuals." (Daniels 1981:147). Any restrictions on the range of opportunities should therefore properly be understood as unjust and not merely due to unfortunate circumstances, concluding that how health is distributed is therefore relevant to the Rawlsian distributional paradigm. By framing health in this way he argues that healthcare institutions should be subsumed under the principles of distributive justice and therefore subject to the principles that would be chosen in Rawls' original position in terms of securing fair equality of opportunity and the distribution of social goods. His claim is that, "The loss of function associated with disease and disability reduces the range of opportunities open to us compared to what it would be were we healthy or fully functional. By keeping people functioning normally, we protect their range of opportunities. If we have a social obligation to protect opportunity in this way, then we have a general framework for thinking about justice and health." (Daniels 2008: 21).

[2] This assumption is contested by, amongst others, Norman Daniels' whose 2008 *Just Health* addresses to the upstream social determinants of health; shifting his focus from fair distribution of healthcare specifically to the fair distribution of all other social goods that contribute to or disadvantage health.

A comparable instrumentalist account on the value of health focuses on how health promotes individual capabilities since the opportunity account is "insufficiently sensitive to the differences between individuals' capacities to transform resources into functionings." (Weinstock 2010:111). This view, attributed to Amartya Sen and expanded by Martha Nussbaum, is concerned with what people do with the resources available to them: capability is understood to be "the set of 'functionings' – the various 'doing and beings' – that a person can achieve (but may decide not to)." (Peter 2001:162). It is distinct from Daniels' inasmuch as individuals' personal or social circumstances are taken into account and allows for people to choose between possible alternative lives, thus better accounting for the differences between people. The value of health therefore rests on its contribution the range of capabilities people have which they can transform into chosen actual functionings. (Weinstock 2010:111 & Mahowald 2008:25). These positions, concerned with equal distribution of opportunities or capabilities respectively, maintain that health contributes to securing these ends which are essential for people to achieve important life goals. Both Sen's Capabilities approach and Daniels' Fair Equality of Opportunity approach assign instrumental value to health by detailing the type of beneficial ends that health can achieve or contribute to.

There are however also good reasons to suggest that health is of intrinsic value and can be considered a good in and of itself and valuable independent to what it can help one achieve. The specific disvalue of one who lacks health (the patient), "is in an altered existential state – anxious, dependent, vulnerable and impeded in the pursuit of his daily life." (Pellegrino 2005:474). Poor health and disease are often (though not necessarily always) characterised by pain and suffering and since it would be legitimate to claim that either of these states are intrinsically bad, health, if viewed as the absence of pain and suffering can be therefore said to be of intrinsic as well as instrumental value. Tom Sorell suggests that poor health is more intrinsically bad than other bad social conditions and states that, "it is hard to deny that poverty is bad; that unemployment is bad; that illiteracy is bad; yet the badness even of these things is eclipsed by the by the badness of catastrophic life-threatening disease, or the badness of intense, unrelieved pain." (Sorell 1998:56).

While it is possible, as per luck egalitarian thinking, that health is of not necessarily of greater moral value than any other social goods, no one claims that it is of no value and disagreements on the value of health are not disagreements so much as different conceptualisations of what makes health morally significant. Whether health is understood or believed to be of either instrumental or intrinsic value, it is

clear it is an important social good and fair healthcare distribution, as the mechanism through which health is achieved, should therefore properly be the subject of ethical enquiry.

1.2 – Defining Health

Daniel Weinstock describes the range of available definitions for health as existing on a continuum between two extremes: inclusive and operational (or reductive) where inclusive definitions are "maximally capacious conceptions that essentially equate health with well-being." (Weinstock 2010:107). The most well-known inclusive definition of health is that of the World Healthcare Organisation (WHO) which, despite substantial concerns on the implied medicalisation of welfare, has remained unaltered since 1948; it defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3] At the opposite end of the spectrum are definitions that attempt to define health in quantifiable and calculable terms, these focus on assigning measurable units to health and are generally appealed to by supporters of utilitarian models when attempting to resolve healthcare allocation problems. Such reductivist understandings of what constitutes health are "quantitive conceptions that attempt to reduce all aspects of health to some meta-value in terms of which they can all be given quantitive expression." (Weinstock 2010:107), but do not seem to provide useful descriptions beyond their use in utilitarian allocation discussions concerned with cost effectiveness like Quality Adjusted Years (QALYS).

Since a core function of healthcare funders is to provide coverage for services that ensure health, they need to have a workable definition of the concept in order to make allocation decisions; the type of definition they choose is important because "definitions of health involve in part decisions about what to prioritize among the goods included within the range of the term." (Weinstock 2010:106). A widely inclusive definition such as that of the WHO is problematic since its expansive nature implies that funding should be provided for more than medically necessary interventions; this would go far beyond a Medical Scheme's expected mandate and would place excessive strain on already limited resources. Such welfarist definitions disregard the possibility that, "other benefits and health benefits are in "separate spheres" and merging them will make our health prioritization strategy both ethically compromised, and practically unworkable." (Bickenbach 2016: online). On the other hand, while a

[3] http://www.who.int/about/definition/en/print.html

purely reductivist understanding is less likely to jeopardise the available pool of funds, it can be shown to be discriminatory and hinder access to necessary healthcare[4].

Multiple definitions exist on the continuum between these two extremes so finding a philosophically perfect definition is unlikely and probably unnecessary for healthcare funders and extensive attempts to do so would ultimately hamper decision-makers rather than enable already complex decisions. Given the specific context of private healthcare funding, it is therefore sufficient to appeal to more biomedical definitions of health. Christopher Boorse provides an adequate workable biomedical definition of health: having identified that the major themes in the literature of health definitions all appeal to normal physiological functioning he proposes the following definition: "Health in a member of the reference class is normal functional ability: the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency." (Boorse 1977:562), where the reference class is "a natural class of organisms of uniform functional design; specifically, an age group or sex of a species." (Boorse 1977:555) and should probably be understood in terms of both physical and mental functioning. This would therefore imply that private funding may be legitimately be restricted to scientifically validated medicines, treatments and technologies that can, to a greater or lesser extent, promote or protect the normal species functioning of members of the cooperative scheme.

One objection to the biomedical definition is that it appears to exclude, and therefore discriminates against those who are unlikely to achieve normal functional ability such as the disabled and the chronically ill who "do not perform in a species-typical fashion", so "imposing on them authoritative diagnoses of their quality of life, healthcare distribution becomes ethically suspect." (Silvers 2001:36). Discrimination of this nature is ethically unjustifiable since, if we have any societal obligations to protect health then, arguably, we have an equally valid obligation protect those most vulnerable in this way. However it is reasonable to suggest that in real-world contexts properly trained physicians have the necessary clinical expertise to discern what can be considered normal functioning relative to these specific groups and can therefore treat patients accordingly. This further implies that it is important that the decision-making bodies of funding organisations include suitably and adequately trained clinical experts so that a too narrow and discriminatory understanding of health is avoided.

[4] These concerns will be detailed later in the report.

For healthcare funders, a biomedical definition of health can reasonably be considered an adequate and sufficiently legitimate understanding since this would encompass the reasonable healthcare expectations of the membership whereas broader definitions like that advocated by the WHO are vague and may be deemed "hopelessly amorphous, conceptually confused and difficult to use." (Weinstock 2010:107). The biomedical definition more effectively delineates the organisation's obligation in terms of healthcare provision by properly limiting it to fund for interventions that provide valid medical assistance where physiological or mental health is threatened. Since, "no matter how much of our resources we devote to health care, there will always be something else of medical value that can be accomplished if only we spend a little (or a lot) more." (Friedman 2008:101); the extensive range of existing biomedical needs requiring healthcare interventions can already stretch available resources and expanding coverage to accommodate general welfare needs should not be considered an acceptable use of these funds. The scope of the funding obligation of Medical Schemes can therefore be understood as that which pays for healthcare interventions; where a healthcare intervention is understood as one which is "medically necessary or meets a medical need…when it is reasonable and effective by the accepted standards of medical practice for the prevention, diagnosis, treatment, or amelioration of some disease, injury, or disability." (Horne 2016:1-2).

SECTION 2 - HEALTHCARE RATIONING

> "the case of health-care rationing can be seen as exemplary for the challenges of decision making under conditions of uncertainty and complexity in conflicts that concern fundamental values and material interests alike." (Landwehr 2013: 297).

Healthcare rationing is necessary "whenever health care resources are insufficient to make them available to all who could benefit."(Jecker and Pearlman 1992:80). Rationing (or limit-setting and priority-setting) is generally understood as the way in which various healthcare services are allocated (or funded) according to a ranking of such services, however chosen; it is "the task of determining the priority to be assigned to a service, a service development or an individual patient at a given point in time." (NHS Confederation 2007). Since health is justifiably understood to be an important social good, rationing decisions, be they in the public or private context, are moral issues and therefore should be subject to ethical requirements and constraints. Included among the key features of rationing are that unequal decisions are inevitable since healthcare goods are indivisible (a hospital bed, for example, cannot be shared by several patients at the time of need) and, "both winners and losers from those

decisions have some legitimate or principled claim to assistance. (Daniels & Sabin 1997:312). While there are some that argue against the assumption that rationing is necessary because healthcare needs are inviolate and should accordingly be freely and unreservedly available to all citizens, current realities do not meet this noble standard so there are moral obligations, "to act on the basis of fair adjudication between competing claims." (Gillon 1994:4). Understood this way rationing or limit-setting "decisions are themselves a requirement of justice, since we cannot meet all legitimate needs with limited resources and rapidly improving technologies." (Daniels & Sabin 1997:312).

While is reasonable to suggest that justice, fairness and a sustainable healthcare system are important rationing goals that everyone can agree to in principle, they are not in themselves moral mechanisms and several competing rationing models have been proposed to achieve these moral outcomes. As with most conflicting ethical issues, the prevailing rationing models are either utilitarian or deontological, Frances Kamm illustrates the difference between these broad bases as follows "there is some straightforward sense in which it is a worse world in which five die than in which one dies, even if in some sense it becomes a worse world if people are such that acting on aggregation is acceptable. This makes it possible…to consider a possible conflict between the right and the good." (Kamm 1993:92). The prevailing rationing models can be divided into two broad categories:[5] a Utilitarian account which is concerned with maximising the overall health of the population, and Egalitarian accounts that attempt to correct some form of inequality.

2.1 - Utilitarian Healthcare Rationing

Utilitarian healthcare rationing is concerned with maximising the net health of an entire population and distribution of healthcare must be done in such a way that this outcome is achieved, "utilitarians focus on measurements of health or lifespan. A cost-benefit analysis in terms of the one factor that counts is employed to determine the policy for a population." (Rhodes 2012:5). Healthcare utilitarian accounts generally appeal to the costs and benefits of treatments and Cost-Effective Analysis (CEA) is the preferred methodology for making rationing decisions. CEA generally applies Quality-Adjusted Life-Years (QALYs) as the unit of measurement, "the core concept of the traditional QALY is grounded in decision science and expected utility theory." (Weinstein, Torrance & McGuire 2009: 55). While different

[5] Rationing models specific to macro-level public distributions that consider healthcare distribution in terms of other social goods will be excluded since these are irrelevant considerations in the context of private healthcare funding.

measurement units like Disability-Adjusted Life-Years (DALYs) and Disability-Adjusted Life Expectancy (DALEs) have emerged, QALYs remain the dominant unit of measure and are used as a generic term for the different measurement units. CEA is used to calculate and determine the most effective net health outcome and different types of healthcare services (be it medicines, treatments, services or technologies) will be ranked or prioritised according to which one will achieve the most number of QALYs per dollar spent in order to maximise overall good or aggregate health benefits of the entire population.

The QALY measure "discounts life years compromised by symptoms and functional limitations." (Wikler & Marchand 2001:online) and is determined through surveys designed to establish people's willingness to trade quantity of life years in favour of quality life. Respondents are interviewed and asked to rate different health states on a numerical scale where 0.00 is death and 1.00 is perfect quality of life. The result of this maximising strategy is that healthcare is not allocated to those who "can achieve only fewer additional years at a value of less than 1 and at a higher cost if they are saved from the same threat" (Kamm 2015:2). CEA will assign higher priority to treating conditions where most QALYs for lowest cost will be achieved; in theory, by aggregating QALY benefits of a given treatment across a population, the goal of maximising healthcare benefits is therefore achievable without a rapid depletion of available resources because it considers, "not only the quantity of life saved by healthcare intervention but also its quality. Highest priority is thus assigned to healthcare interventions which involve the lowest cost per unit of health-related quality of life." (Wikler & Marchand 2001:online).

A utilitarian framework is generally applied in collective enterprises and for policy decisions as "the standard that public policy-holders are to use when making collective choices impinging on the community as a whole." (Goodin 1993:245) and can be considered as the "favoured operational ethic," for policy-makers since, "The idea that we are morally obliged to spend our limited resources in ways that do the most good is intuitively appealing." (Lutham 2006:online). Utilitarian calculations are therefore generally applied when making macro-level policy rationing decisions and in the Medical Scheme industry and CEA is an essential tool for designing health plans and the healthcare services (or benefits) that each plan will cover. More robust plans, with 'richer' benefits and fewer limits have higher financial contribution rates and the insured population (as per plan) has an equal entitlement to the same specified healthcare services as and when they are deemed medically necessary. The strategy is necessarily focussed on the maximum benefits that can be achieved with the available financial resources. When people choose to purchase a healthcare plan they can legitimately expect the

organisation to successfully and diligently manage their healthcare funds and needs along with those of the others participating in the cooperative scheme; a utilitarian framework can conceivably be considered a fundamental element in ensuring this obligation of stewardship is achievable.

Besides providing a framework for meeting this obligation of stewardship, utilitarian thinking also claims to be egalitarian and "committed to treating people as equals." (Rhodes 2012:4). This assertion is supported by the argument that since one specific objective outcome measure is equally applied to each claimant, no one can be said to be treated unequally or unfairly – where fairness is understood within a utilitarian conception which disregards differences between individuals as being relevant. In addition, given the complexity of rationing these scarce resources, further support for the use of a utilitarian calculus is that it "is simple and focused on something people do value." (Rhodes 2012:5), and answers the "demand for handy, quantified health outcome measures." (Arnesen & Norheim 2003:84). What these comments suggest is that the appeal of a utilitarian approach seems largely based on finding a usable methodology that provides simple, calculable formulations to resolve what, to date, remains the unsolved rationing problem.

2.1.1 - Objections to a Utilitarian Account

A maximizing strategy is criticised on the grounds that it ignores the morally significant impact of rationing on individuals and does not take into account "the gains or losses that fall upon particular persons." (Lutham 2006:online), and therefore cannot adequately attend to discrete individual needs. For Medical Schemes, when making macro-level rationing decisions for the overall design of health plans, it would be impossible to know every conceivable clinical need or medical treatment so there are unavoidable omissions in the contractual agreements. Herein lies one of the shortcomings of applying a pure utilitarian framework for all healthcare rationing decisions: it is unable to fairly and justly accommodate specific legitimate needs of individual claimants whose healthcare requirements deviate from the norm.

The most commonly cited incident of the failure of a straightforward maximizing and aggregating strategy is the rationing that was implemented in the U.S. state of Oregon which only used cost-effectiveness to rank resource prioritisation notoriously resulting in an outcome that, for example, prioritised tooth-capping above appendectomies because the CEA calculation showed the latter to be less costly and more likely to yield more well-being after treatment without factoring either extent of

medical need or the risk associated with the condition (Beauchamp & Childress 2001:256). While this strategy has since been abandoned in Oregon, it serves as a real-world example of how an unqualified utilitarian approach fails to serve the actual medical needs of the population and illustrates how aggregating benefits to achieve maximum population health can result in a system that legitimately allocates relatively insignificant healthcare benefits to a large portion of the population while compromising on providing care to a smaller, sicker portion of the population who will benefit more from healthcare interventions.

If allocation concerns are only related to the overall health benefits of a population rather than giving attention to how these benefits are distributed among individuals, then severely ill patients may justifiably, according to this view, receive no healthcare benefits at all. The moral concern here is that "the total maximising strategy assumes, controversially, that sufficient [aggregate benefit] can outweigh [the needs of individuals in distress], but in common moral intuition rescuing people from calamities, or averting them altogether, ought to take priority over lesser forms of aid, even where the latter can be provided to many more people for the same cost." (Wikler & Marchand 2001:online). The sole application of utilitarian thinking is particularly inadequate when making micro-level decisions because these cases are specifically concerned with the healthcare needs of individuals and discrete, morally relevant, factors apply and it is morally questionable that the wellbeing of a population should be secured at the expense of individuals in desperate need of medical assistance and "the principle of utility does not have the moral power to dictate a particular medical procedure simply because it has the lowest cost-effectiveness ratio." (Beauchamp & Childress 2001:199).

2.1.2 - Objections to a CEA and the use of QALYs

In addition to these broader objections to using a utilitarian account in healthcare rationing, there are several objections specifically levelled at the CEA model and its use of QALYs as an outcome measure. Three criticisms emerge as the most vexing: firstly, the methodological concerns regarding the questionable objectivity of the measure, secondly, the inherent problem with its egalitarian claim and, finally, that it disregards considerations related to distributive justice.

A problem with using a polling methodology "so as to obtain a consensus of the degree of disutility associated with different states," Weinstock states, "risks smuggling professional and class prejudice into what is then presented as resulting from the application of a scientific, "objective" methodology."

(Weinstock 2010:108). Gleaning responses from people on their willingness to trade life years for quality of life cannot be considered objective as choices are likely to reflect the *preferences* of respondents which would reasonably differ between people as well as over time as circumstances or health statuses change. The mistaken assumption underlying QALY measures is that "quality of life is an objective phenomenon that incorporates autonomy, accomplishments and a reasonable array of opportunities to live a full life." (Bickenbach 2016:online) and that the subjective preferences of respondents are relevant and equally applicable to everyone. QALYs therefore assume that all health gains have equal weight without considering the differences between individuals or communities and that neither the "differences in preferences for our own health across different individuals are…to count," nor "the preferences of society or the community for variations in the weights to be attached to different groupings in the community." (Mooney 2000:212), so for example those with poorer health or those more likely to benefit from healthcare interventions may justifiably receive higher prioritisation than the rest of a given community.

Secondly, while QALY proponents claim it is egalitarian inasmuch that the benefits apply equally regardless of who receives it, there are valid ethical concerns with this claim of equality which conflicts with the more generally accepted egalitarian moral conception that, "the life and health of each person matters, and matters as much as that of any other and that each person is entitled to be treated with equal concern and respect both in the way health resources are distributed and in the way they are treated generally by health care professionals, however much their personal circumstances may differ from that of others." (Harris 1997:120) The first objection to the QALY equality claim is that what "is to be given equal weight is not persons and their interests and preferences, but quality-adjusted life-years." (Harris 1997:118), so what matters is not individual lives, but life-years which seems to imply that the equal treatment of a person is less important than an equal allocation of quality life years. This concern does however not show that QALYs lack an equitable base, only that what is being measured equally denies what most consider a more fundamental egalitarian requirement: the equal moral worth of each person.

A third concern regarding the claim of equality is frequently raised in the literature[6] and referred to by John Harris as the double-jeopardy problem. It reveals the inherent contradiction of the equality claim by

[6] Harris (1997), Bickenbach (2016), Hope (1996) and Kamm (2015)

exposing its unavoidable discrimination and unequal treatment of certain groups such as the elderly, the disabled and the severely ill who will experience two levels of disaster: firstly, their current life or health circumstances already mean they have a relatively poor quality of life, and secondly, QALYs require that they also be ruled out as candidates for life-saving treatments (Hope 1996:195). Since QALYs are concerned with increasing the overall health of the population, resources will go to those most likely to gain the most life-years which necessarily excludes these groups since, all things considered, they are unlikely to achieve as many years as younger, healthier people.

The moral requirement of justice that, "each individual in society be considered as an irreducible source of moral claims (that is, the import of the claim they make upon social resources does not depend on the contribution that the satisfaction of their interests makes to the aggregate.)" (Weinstock 2010:116), is absent in the CEA utilitarian calculus since this view does not assign any value to individuals beyond their ability to contribute to the overall good. This final significant concern with the utilitarian framework is that its failure to address how and to whom health benefits are distributed leads to the concerning implication that those most desperately in need of healthcare interventions will not necessarily receive assistance if it does not contribute to the overall health of the population. Since formal justice requires that similar cases be treated similarly except where good reasons exist for differential treatment, CEA explicitly disregards this constraint by "deliberately ignoring relational and relative differences between individuals.", inasmuch as, "Who will get the benefit and who will not, how they will use the benefit, what will happen to those who don't get the benefit, are all irrelevant." (Rhodes 2012:4-5) It is this indifference to relevant moral (or clinical) differences between people that leads to the questionable conclusion that it is acceptable to aggregate relatively small benefits, such as tooth-capping, against significant benefits to a smaller sicker portion of the population. "If what matters the most is the number of life-years the world contains," Harris concludes, "then the best thing we can do is devote our resources to increasing the population." (Harris 1997:119).

Nevertheless, "concerns about CEA do not undermine its usefulness in health-care decision-making," (Fenton 2010:140) and few commentators on the rationing debate consider its wholesale dismissal feasible since deontological person-centred accounts generally neglect to consider that the sustainability of the healthcare system for the entire population is an important ethical concern. Despite these objections to the utilitarian CEA model, its population-centred methodology that attends to these considerations in conjunction with focused financial accountability is fundamentally important to

rationing decisions; particularly so when that population is a cooperative scheme where the overall financial strength and sustainability of the scheme can be viewed as a fiduciary obligation to the members who have entrusted the responsibility of healthcare funding to an organisation. There is however an uneasy suspicion that a straightforward application of population-centred utilitarianism means that it is, in a sense, acceptable to use individuals as a mere means to an end, where that end is the overall health and financial sustainability of the scheme. Ranaan Gillon further warns that using apparently simple solutions like QALYs diminishes the moral debate by seeking "to convert…essentially moral choices into apparently scientific, numerical methods and formulas." (Gillon 1994:6) which dismiss both the moral worth of individuals and important relevant differences that require differential treatment in order to be considered just.

2.2 - Egalitarian Healthcare Rationing

The various non-utilitarian rationing models are not necessarily categorised as egalitarian in the literature, but upon investigation each can be regarded in terms of correcting for some form of inequality. These accounts are not primarily concerned with the overall health of the population but aim to achieve an equitable and fair healthcare allocation for each person in the population; they identify the "morally relevant qualities of individuals and make these the determining ground of individuals' entitlement to healthcare." (Jecker and Pearlman 1992:80). This concern for the individual is grounded in the importance of the moral worth and dignity of each person which is understood to be "the primary unit of respect, concern and value… Saving one is as if one had saved a million when doing so is the only course consistent with showing the highest respect for humanity in each person." (Kamm 1993:92).

2.2.1 – Prioritisation[7]

Prioritisation is the most widely discussed non-utilitarian rationing model and traditionally understood in terms of assigning priority to those who, in terms of health, are the worst-off or the most urgently in need of medical assistance (where such needs are understood to be objectively necessary and would be relevant to anyone with a similar health deficit regardless of personal preferences). Assigning priority to the worst-off may be considered an egalitarian account since its implied goal is to improve the poor health of the sickest, thereby addressing the inequalities of the health statuses between individuals. Bickenbach places it squarely within an egalitarian framework: "Making the case for allocation in terms

[7] Some authors refer to prioritisation as prioritarian (or prioritarianism) but no clear distinction is made in the literature.

of who is "worst off" reflects the version of egalitarianism called prioritisation…in which the distribution of a resource is guided by the intuition that the worst off have more to gain and should be given priority, not, like in the utilitarian approach in terms of great welfare benefit, but because of greater needs." (Bickenbach 2016:online). Describing prioritisation as egalitarian is however contested by Dan Brock who maintains that since improving the health status of the worst-off is not based on a commitment to achieve equality it should therefore not be conceived as such; his claim is that since the goal of prioritisation is to improve the "individuals' positons the worse off they are, without regard to whether doing so makes the overall distribution more equal" (Brock 2012:online), it cannot be egalitarian. He is however not clear why an account that can potentially correct for health inequalities, albeit unintentionally, should not be described as egalitarian merely because equality is not its stated goal.

Justification for prioritising healthcare according to the worst-off rests on three arguments: firstly it claims that healthcare benefits are more morally valuable the worse-off the patient is because a healthcare intervention should be allocated, "to where it will do more good, not in the sense in which doing so will generate a bigger health benefit, but in the sense in which a given benefit means a bigger *relative* improvement for the worse-off individual. ...This argument rests on the claim that benefiting people matters more, morally, the worse off those people are." (Fenton 2010:141). Secondly, the account appeals to the commonly accepted notion that healing is the end of medicine and therefore the ethical priority can be understood in terms of healing those most in need and, thirdly, it appeals to the requirements of justice since poor health is bad it can properly be considered a morally relevant, distinguishing factor necessitating differential treatment.

While Rawls does not include healthcare a primary social good or its institutions part of the basic social structure, prioritisation, which suggests that healthcare be distributed in such a way that it improves the circumstances of the worst-off, can conceivably be a Rawlsian notion with commentators such as Lutham and Daniels describing prioritisation to the worst-off as a Maximin strategy requiring that allocation rules "make the position of the least advantaged person as good as possible." (Lutham 2006:online). Rawls's Difference Principle states that unequal distributions of social goods "are just only if they result in compensating benefits for everyone, and in particular for the least advantaged members of society." (Rawls 14-15) and the application of this principle in healthcare should be understood in terms of providing greater benefits to those who would directly benefit from healthcare interventions in such a way, "so as to improve the long term expectation of the least favoured." (Rawls 1971:101), where the

least favoured are the sickest. Rosamund Rhodes suggests that prioritisation is therefore grounded in Rawls's Difference Principle since prioritisation, "allocations aim at the identification of unwanted inequalities and then try to redistribute resources so as to compensate for or correct them. Prioritarian allocations reflect a concern for how individuals fare in relation to each other and attempts to advantage those whose position is worse than others." (Rhodes 2012:8).

2.2.1.a – Objections to Prioritisation to the Worst-Off

While the prioritisation to the worst-off account is generally well supported, there are several concerns with the account. The first objection to giving absolute priority to the worst-off is that it appears to disregard potential medical outcomes and in so doing fails to explain to whom resources are to be allocated when claimants have equally poor health statuses. While prioritisation is more generally understood in terms of the needs of the worst-off, there is a secondary conception of the term which is more specifically concerned with health outcomes for the individual. This view differs from the common construal of prioritisation and requires that scarce resources be allocated "to individuals likely to receive the greatest medical benefit while denying them to patients likely to gain the least." (Jecker and Pearlman 1992:87). This secondary prioritisation account is concerned with the scarcity of resources and promotes a more efficient and effective use of the limited resources which supports intuitive belief that a scarce healthcare resource, e.g. an organ, need not be allocated to patients with severe comorbidities and very poor prognoses since "a scarce medical resource should be distributed only to patients who have a reasonable chance to benefit," and, "Ignoring this factor is unjust, because it wastes resources" (Beauchamp & Childress 2001:266). This conception has not received as much attention in the literature, possibly because the achievement of some health benefits is an implicit underlying assumption of all healthcare rationing models, and it cannot be claimed that it has emerged specifically as a response to the equal needs problem. Nevertheless, while it may not be concerned with the initial state of ill health, given its general framing in terms of prioritisation, it could be considered a useful caveat to the worst-off account that explicitly addresses the missing medical benefits problem.

A second problem is how to determine who is the worst-off; if micro-level funding decisions were to be made according to the worst-off account a clear determination of who qualified as the worst-off is crucial. Cookson & Dolan suggest that determining the worst-off may be done in terms assessing the degree of ill health and they appeal to the traditional clinical Rule of Rescue which broadly defines the worst-off in terms of ill health that "would encompass immediate pain and suffering…as well as

immediate threat to life." (Cookson & Dolan 2000:324). This suggestion is however not a particularly a useful guideline since the South African healthcare funding industry is required to treat immediate threats to life as emergency care and these cases are explicitly included for cover in health plan contracts so are unlikely to require additional ethical deliberation. While the rule of rescue may provide some guidance in specific circumstances, it is not broad enough to provide an adequate response to the problem of identifying the worst-off when making funding decisions.

If the worst-off are determined to be those who have the poorest possible level of health, assigning absolute priority to these claimants may result in what Brock calls the bottomless pit problem. This third objection is specifically concerned with the scarcity of resources which the traditional prioritisation account neglects to properly consider. Those who are conceivably defined as the very worst-off "for example, as the very severely cognitively and physically disabled who have extremely low health-related quality of life," would require significant "near-limitless resources" (Brock 2012:online), which may only achieve minimal, if any, health improvements. In a cooperative scheme where resources are limited and need to be fairly distributed this could be deemed as wasteful and unfair to the rest of the population.

However even if an acceptable methodology emerges that can fairly and legitimately determine who is the worst-off, a further ethical concern with the prioritisation account is that it does not clearly justify why those with lesser medical needs should be deprioritised so, "if we must treat the most urgent needs, or meet the strongest claims, of individuals first,… individuals with less urgent needs or weaker claims, no matter how large their number, would not be treated before anyone with a more urgent need or stronger claim." (Brock 2010:online). If this is true and if, as per the bottomless pit problem, vast resources are to be directed to the very worst-off, giving absolute priority to these individuals suggests that it is permissible that the not-quite-worst-off not receive timeous medical assistance; under such circumstances the health status of the lesser ill could conceivably degenerate to the point where they become the worst-off before receiving treatment and an account of healthcare allocation that suggests that a significant and unnecessary decline in health is acceptable is morally questionable. Nevertheless, while supporters of the prioritisation to the sickest should address these objections, the model has a good moral foundation since, "Giving no priority to the sickest…violates the strong moral concern many people feel for the most vulnerable among us." (Daniels & Sabin 2008:3).

2.2.2 – Personal Responsibility Rationing

Also referred to as rationing based on lifestyle choices or behaviour, this type of rationing suggests that less priority be given to those who bear some responsibility for their poor health so, "when disadvantages are undeserved, then the moral baseline would appear to be equality, since it eliminates those undeserved disadvantages." (Brock 2012:online). It is grounded in the Luck Egalitarian framework and the, "distributive significance they assign to the distinction between the chosen (associated with responsibility and the voluntary) and the unchosen (luck, or the absence of the voluntary)." (Knight & Albertsen 2014: 165). Proponents of luck egalitarianism maintain that it is bad if people are disadvantaged by factors over which they have had no control and therefore just distribution should focus on correcting disadvantages created by vagaries of brute luck, not for those personally and autonomously generated. While it is true that these authors do not consider health or healthcare to be more significant than any other social values, it does not follow that healthcare distribution be excluded from the precepts of their framework since luck egalitarianism "sees all inequalities in access to advantage that result from factors over which the individual had no control as unjust and thus as warranting rectification." (Segall 2010: 348). This view seems particularly relevant in cooperative schemes where risks and benefits are shared amongst a population and where participants all contribute to the risk pool. Since, by nature health insurance schemes are set up in a way that the healthier population will subsidise the unhealthier population, there seems to be a strong case for suggesting that it is unfair for the former to carry the additional burden of healthcare costs that could have been avoided through less risky behaviour by their unhealthier counterparts.

While this framework is not without merit and, "can make a valuable contribution to our moral assessment in the complicated areas of health and healthcare." (Knight & Albertsen 2014:165), it still needs to overcome some significant objections before its application to healthcare rationing can be justified. The first concern is, "the very practical problem of distinguishing causal responsibility from moral responsibility." (Bickenbach 2016:online) which means it is not possible to straightforwardly claim that such behaviour, risky or otherwise, is necessarily an autonomous choice because "in general, individuals do not make choices in a social and cultural vacuum. Their choices are not determined by circumstances, but they are to a great degree infected by them." (Weinstock 2010:115). A related point is that currently there is no definitive evidence to suggest that behavioural choices such as excessive alcohol use is "a choice rather than a genetically predisposed behaviour." (Bickenbach 2016:online). Furthermore, while there may be significant statistical evidence that one's health status can be traced to

poor lifestyle choices, "it is also true that statistical generalities do not determine the fates of individual persons." (Lutham 2006:online).

The causality concern aside, there is also the issue of what types of behaviour would qualify as risky and subject to limitations. If funders were to implement limitations to healthcare coverage based on lifestyle choices they would need to apply these restrictions impartially to *all* types of risky behaviour not only the "most clearly unpopular candidates" (Harris 2001:online) like nicotine and alcohol use: the two boogeymen of healthcare. If voluntary choice is cited as a relevant principle for funding limits then it would have to be applied to all activities to avoid the pitfall of arbitrariness and moral bigotry; limitations on risky behaviour would therefore need to extend to, for example, professional athletes, people involved in rescue services (professionally or otherwise), those who participate in unsafe sexual activities and even those who choose to remain in highly stressful jobs. Limitations cannot be arbitrarily imposed on selected types of behaviour without the institution making implicit moral judgments about certain types of behaviour and, by extension, the people making those choices.

The final objection to this type of rationing is that it is paternalistic and that respect for autonomy is violated if personal choice is sanctioned and subject to restrictions. Defending such paternalism on the "grounds of beneficence for the person whose autonomy is limited." (Fisher 2001:17) would be questionable and, even in the domain of cooperative schemes that are tasked with guarding the healthcare resources of a population, it is uncertain that an organisation has the right to impose penalties for certain types of behaviour, because, "There are a range of differences among individuals that reflect their different values, and it is on this view just and appropriate that people be able to make choices even within the domain of health care that reflects their legitimate differences." (Weinstock 2010:109). In addition there would seem to be an inherent contradiction were the organisation to claim to respect autonomy on the one hand, by respecting and adhering to the choices people have made in terms of selecting their healthcare plans, but not on the other hand, by denouncing certain personal choices and restricting healthcare funding based on these choices. The ethical tension here is that while these organisations do have an obligation of stewardship, it does not follow from this that they may violate other important principles in the pursuit of this requirement. Nevertheless, were limitations applied to all types of risky behaviour and communicated and accepted by subscribers prior to joining a scheme, this violation of autonomy may be mitigated.

2.3 - The Current Status of Rationing Debate

The one thing that all commentators on the rationing problem seem to agree on is that the problem remains unresolved. While these rationing models can be shown to be guided and determined by reasonable ethical concerns they are also equally subject to valid ethical objections and endorsing a specific account can therefore be considered a reflection of one's own underlying moral commitments; "The weightings that different people give to different moral concerns, such as helping the worst off versus not sacrificing achievable medical benefits, probably depend on how these moral concerns fit within wider moral conceptions people hold."(Daniels & Sabin 1997:321). When such moral conceptions are reasonable, valid and principled there is no cause to dismiss them and accepting such moral pluralism can properly be considered a manifestation of respect for autonomy; this does however suggest that the rationing problem is unlikely to be resolved and why currently, "A fragile truce has been reached in which it has been admitted that we cannot accept either a pure utilitarian CEA approached unalloyed with considerations of fairness, or a purely egalitarian lottery approach unaffected by intuitions concerning the significance or ineffective use or valuable resources." (Bickenbach 2016:online). In addition, what seems clear in the prevailing conflict between rationing models is that these are based on considerations of either the wellbeing of the population or the wellbeing of the individual which implies that these are discrete entities. It is unlikely that a resolution will be reached if the interdependency of the two entities is not at the forefront of the debate and if the latter remains solely concerned with "balancing population-centred concerns against patient-centred ones." (Daniels & Sabin 1998:32), since "ill health restricts both personal freedom of action and societal functioning." (Heubel & Biller-Adorno 2005:13). While it is important to recognise and attend to the problems related to the scarcity of resources, it is equally important that this not be done at the expense of the health of the individual. There is a commonly accepted societal obligation to aid the most vulnerable (which can justifiably include the elderly) and, since health is an important social good, this obligation should extend beyond merely protecting the overall wellbeing of a population. The dual population- and person-centred obligations that inform rationing seem to be constrained by the following considerations as well: the formal requirements of justice and respect for the equal moral worth of each person should be cornerstones for making rationing decisions as these are necessary to ensure that healthcare allocations do not arbitrarily discriminate against any individual or group.

SECTION 3 - HEALTHCARE ETHICS

3.1 - Principlism

While several ethical frameworks exist in the Bioethical field, the most influential ethical system in bioethics is principlism as described by Tom Beauchamp and James Childress's *Principles of Biomedical Ethics*. First published in 1985 it sketches out four prima facie primary principles, each with its own set of derivative rules, which the writers claim is a framework for identifying and reflecting on moral problems. While their view is not without detractors, the general support and almost unilateral, sometimes exclusive, reference to their work by bioethical commentators is indicative of its dominance in the bioethics field: "I think the four principles should also be thought of as the four moral nucleotides that constitute moral DNA – capable, alone or in combination, of explaining and justifying all the substantive and universalisable moral norms of health care ethics and I suspect of ethics generally!" (Gillon 2003:308) The four principles of principlism are: Respect for Autonomy, Nonmaleficence, Beneficence and Justice. While Beauchamp and Childress insist on the *prima facie* nature of the principles (obligatory unless they conflict with an equal or stronger obligation) and therefore that no single principle is more important or weightier than another, "beneficence provides the primary goal and rationale of medicine and health care, whereas respect for autonomy (along with nonmaleficence and justice) sets the moral limits on the professional's actions in pursuit of this goal." (Beauchamp & Childress 2001:177). While no one principle can consistently have priority they do acknowledge that there may be instances of conflict but accept that moral diversity and moral disagreements occur and that, "Such disagreement does not indicate moral ignorance or moral defeat. We simply lack a single, entirely reliable way to resolve all moral disagreements." (Beauchamp & Childress 2001:21); when conflicts between the principles occur they suggest these can be resolved through deliberation on the specification and balancing of the principles to resolve the conflicts; where the specification of the range of norms is considered an important process for policy development, and balancing is more relevant when principles conflict in specific individual cases. The principles are advocated as a guide for the moral behaviour of healthcare professionals and are summarised below according to their relatively specific understanding of the concepts as they relate to healthcare.

3.1.1 - Respect for Autonomy

This first principle is grounded in the Kantian tradition which requires us to always treat human beings with dignity based on their worth as autonomous, rational agents: "respect for autonomy flows from the recognition that all persons have unconditional worth, each having the capacity to determine his or her

own moral destiny. To violate a persons' autonomy is to treat that person merely as a means, that is in accordance with other's goals without regard to that persons own goals." (Beauchamp & Childress 2001:63-64). For principlism the mere attitude of respect for autonomy is insufficient; the *actions* of the moral agent must acknowledge other's rights to have views and take action based on their values and beliefs. The principle encompasses both negative and positive obligations: healthcare professionals have a negative obligation not to control or constrain the autonomous actions of others and a positive obligation to disclose all relevant information to patients to promote autonomous decision-making. "Respect for autonomy obligates professionals in health care…to disclose information, to probe for and ensure understanding and voluntariness, and to foster adequate decision-making." (Beauchamp & Childress 2001:64). A core element of their conceptualisation of autonomy is the importance of voluntariness, understood as actions (or decisions) that people take "without being under the control of another's influence." (Beauchamp & Childress 2001:93). Derivative rules of this principle include honesty, protection of privacy and confidentiality, obtaining consent and helping others make decisions when asked. (Beauchamp & Childress 2001:65). Despite the writers not specifying it as such, the principle of respect for autonomy is often given priority by commentators like Gillon who argues that it is the "first among equals" (Gillon 2003:310).

3.1.2 - Nonmaleficence

The principle of nonmaleficence asserts a negative obligation not to harm. While Beauchamp and Childress deny that any one of the four principles has primacy or overrides the other principles, they do suggest that under certain circumstances the negative obligations of nonmaleficence "are more stringent than an obligation of beneficence; and, in some cases, nonmaleficence overrides beneficence, even if the best utilitarian outcome would be obtained by acting beneficently." (Beauchamp & Childress 2001:115). Their understanding of this principle only requires that agents *intentionally* refrain from taking actions that cause harm, where harm is not necessarily violating someone's rights or wronging them, but rather construed as "thwarting, defeating, or setting back some party's interests." (Beauchamp & Childress 2001:116); and these harms are generally construed in terms of significant physical and mental harm. The principle includes obligations of due care: to not impose risk of harm by being intentionally or unintentionally negligent. The derivative rules of nonmaleficence include injunctions on killing, causing pain and suffering, incapacitating, causing offence and depriving others of the goods of life (Beauchamp & Childress 2001:117).

3.1.3 - Beneficence

Beauchamp and Childress claim there is a moral requirement to contribute to the welfare of others and this obligation is met through the principle of beneficence. This principle is more demanding than that of nonmaleficence since, whereas the latter only requires that one refrains from actions that harm others, the principle of beneficence requires that agents "act for the benefit of others…[to] further their important and legitimate interests." (Beauchamp & Childress 2001:166). Their conception of beneficence extends beyond this positive obligation to include a utilitarian requirement of balancing the "benefits and drawbacks to produce the best overall benefits" (Beauchamp & Childress 2001:165), because merely attending to acts that benefit others is not broad enough so appropriate beneficence requires considerations of utility. While it seems questionable to subsume a utilitarian account into what is generally construed as deontological framework, they defend it by suggesting that it not be viewed on terms of classical unconstrained utilitarian thinking, but "that the principle of utility that we defend can be legitimately constrained by the other principles we advance." (Beauchamp & Childress 2001:167). The inclusion of a utilitarian element is appropriate since they claim a straightforward application of the principles of nonmaleficence and beneficence does not provide an opportunity to address the risks and costs associated with these actions and the utilitarian constraint is necessary to ensure that these issues are taken into consideration (Beauchamp & Childress 2001:166); they therefore advocate the use of analytic techniques like QALY-based CEA, but only as aids to help decision-making and subject to the constraints of the other principles that may "point to different conclusions." (Beauchamp & Childress 2001:213). The general forms of positive beneficence include protecting and defending the rights of others, preventing or removing conditions that may harm others and helping and rescuing those with disabilities or in danger. One important distinction they make between nonmaleficence and beneficence relates to the role of impartiality; whereas nonmaleficence must be followed impartially, they suggest it is permissible to be partial when attending to the requirements of beneficence: "We are morally prohibited from causing harm to anyone (a perfect obligation). However, we are morally permitted to help or benefit those with whom we have a special relationship." (Beauchamp & Childress 2001:168).

3.1.4 - Justice

The principlism account of justice maintains that the requirements of justice cannot be met through arbitrary and capricious allocations of social benefits and burdens so proper standards of justice are needed "whenever persons are due benefits or burdens because of their particular properties or circumstances…A holder of a valid claim based in justice has a right, and therefore is due something."

(Beauchamp & Childress 2001: 226); injustice is therefore viewed as occasions where such claimants are wrongfully denied that to which they have a right or where these benefits are distributed unfairly. The framework distinguishes between the formal and material requirements of justice; the former requiring equal treatment of people unless relevant factors permits differential treatment. This formal requirement is however problematic since it is indeterminate on what factors are relevant, it "merely asserts that whatever respects are relevant, persons equal in those respects should be treated equally." (Beauchamp & Childress 2001:227). In contrast material principles of justice provide substantive content to these formal requirements by specifying relevant characteristics that inform just allocations. Beauchamp & Childress point out the practical and theoretical difficulties in justifying the suggested relevant principles and that these theories remain abstract and "provide only rough guidelines for forming specific policies or taking concrete actions," so, "We need further moral argument that specifies and balances principles and assesses competing claims in order to determine which concrete aspects of a situation are morally relevant and decisive in forming reasoned judgments." (Beauchamp & Childress 2001:229).

Beauchamp and Childress identify but do not subscribe to any specific general theory of justice (utilitarian, libertarian, communitarian or egalitarian) nor to any associated distributive account, but rather recommend that a comprehensive and coherent system that combines the requirements of both justice and utilitarianism[8] be designed, "Although justice and utility may appear to be opposed, both are indispensable in shaping a health care system." (Beauchamp & Childress 2001:262). Their suggestion for a just healthcare system is that it should have four objectives. Firstly, unobstructed universal access to a minimum of health care; secondly, to develop acceptable incentives for physicians and consumer-patients; thirdly, construction of a fair rationing system that does not violate the decent minimum requirement, and finally, that the system be implemented incrementally. (Beauchamp & Childress 2001:262). They acknowledge the benefits of both utilitarian strategies that attend to social efficiencies and more patient-centric egalitarian accounts and claim that these are not necessarily mutually exclusive and can be combined through specification and balancing though they do not provide additional insight on how this system can be achieved. In addition to these allocation policies, they consider the prospect of success (of a treatment) a relevant allocation criterion and claim that it is an "unargued premise, that judgments about medical utility should figure into decisions to ration scarce resource," and that,

[8] There seems to be a contradiction in the literature inasmuch that Beauchamp & Childress include utilitarianism as a specific theory of justice (p.231) and then later suggest it is an account in addition to and separate from other theories of justice. (p.262)

"Differences in patients' needs and their prospects for successful treatment are relevant considerations." (Beauchamp & Childress 2001:267).

3.1.5 - Some Observations on Principlism

Beauchamp and Childress claim that their principlism framework with its four principles "derive from considered judgments in the common morality and medical traditions," and is their attempt to put these elements into a "coherent package." (Beauchamp & Childress 2001:23). Despite its widespread use in bioethical literature, the framework is not without its critics; John Harris contends that the principles are open to broad interpretation, should not be considered the best way to approach all bioethical dilemmas and, if followed, claims (somewhat melodramatically) that it would "lead to sterility and uniformity of approach of a quite mind bogglingly boring kind." (Harris 2003:303). Daniel Callahan also raises concerns regarding the inability of the four principles to inform real substantive ethical debate, being "Too narrow to do all the necessary work of ethics, too individualistic to help us answer questions about the appropriate needs of communities, and too mechanical to encourage some necessary analytical and personal skills." (Callahan 2003:291). Despite Gillon's earlier comment about their potential universal applicability to all health care and possibly general ethics, the four principles were specifically designed to guide the behaviour of healthcare professionals and seem too narrow and descriptive in their conception to have broader applications without a more thorough analysis of the principles. The unaddressed limitations of the concept of autonomy and the questionable general moral obligation of beneficence are particularly noteworthy.

While principlism addresses the need for surrogate decision makers who "are authorized to reach decisions for doubtfully autonomous or nonautonomous patients." (Beauchamp 2001:98), the principlism narrative on respect for autonomy does not consider the common concern with this concept which restricts the scope of the moral community with its a focus on the rationality of agents; therefore, while it acknowledges that those with compromised autonomy may require others to make decisions on their behalf, there seems little indication in principlism of why or in which way respect for autonomy is to be extended to these individuals. If the concept of autonomy is limited to the two conditions that they describe: "(i) liberty (independence from controlling influences) and (2) agency (capacity for intentional action)." (Beauchamp & Childress 2001:58), then the implication is that certain groups such as the very young, the mentally disabled and those in vegetative states may be excluded from considerations of respect . The concern is that "when autonomy displaces inherent dignity, large numbers of humans are

deprived of their humanity and personhood." (Pellegrino 2005:479). This is not to say respect for autonomy is by any means an invalid principle, merely that in order to ensure respect is properly inclusive, it should be subsumed into the broader conception of dignity since "there is no particular standard of rationality and autonomy a person could fail to meet that would render them as lacking the worth their dignity accords them," (Byers 2016:64). Therefore dignity, unlike the commonly used conception of autonomy, is not diminishable nor dependent on notions of voluntarism and rationality and requires that every person, by virtue of their value as human beings, are entitled to be treated with respect for their persons and not, as per the Kantian notion, used merely as means to another's ends: "It is the value of dignity that grounds, or provides the point of, the prohibition on the use of persons as mere means." (Byers 2016:66).

3.2 - Broader Bioethical Considerations

Objections levelled against applying market mechanisms to healthcare distribution generally claim that, "a form of economic egoism has corrupted the health care system, replacing the caring and professional models with that of competing self-interests, encouraging greed, confusing professional interests with profit, depersonalizing patient relationships, diluting benevolence and charity with a concern for economic viability." (Werhane 1990:8). Claims regarding the conflict between the healthcare and organisational ethical frameworks generally originate from within the healthcare environment and only very committed libertarian views suggest market mechanisms are sufficient and appropriate to distribute healthcare; however, given that it is true that "pure market solutions do not provide anything for those that are too poor to enter the market." (Lutham 2006:online), the concerns raised by healthcare ethicists denouncing market mechanisms in health care are legitimate and not necessarily allayed by the Principlism account. Two broader issues prevalent in healthcare ethics may provide more insight into this ethical tension; firstly, the personal nature of the patient-physician relationship that some claim drive physicians' ethical obligations seems incompatible with business ethics and, secondly, that healthcare, as an important social good, should not be treated as a mere commodity.

3.2.1 - Physician-Patient Relationship

"The end of clinical medicine is the good of a particular patient who consults a particular health professional in particular circumstances. Any principle, rule, guideline or practice that frustrates, compromises or endangers that end is an unethical and immoral infringement of the ethics of clinical medicine, and thus of the human covenantal relationship that underlies that ethic." (Pellegrino

2005:475). While this view is usually related to the character of healthcare professionals and therefore within a Virtue Ethics framework, most healthcare ethicists, including Beauchamp, agree that the end of medicine is healing and to achieve this end, healthcare ethics should be understood as, "Traditional principles…that govern the physician-patient relationship," (Mariner 1995:237). The personal nature of the physician-patient relationship and the associated responsibilities of healthcare providers is a fundamental element that defines the field and some, like Edmund Pellegrino, claim that it should be the only determinant of their obligations: "Physicians have no choice but to put their patients' needs first if they adhere to their covenant of trust to which they are bound in their relationships with *their* patients." (Pellegrino 1994:507). Principlism too assumes this relational nature and the account is introduced by following premise: "Special roles and relationships in medicine require rules that other professions may not need." (Beauchamp & Childress 2001:5); the assumption of a distinct relationship is further implied in the account by the way in which the model explains the principle of beneficence by acknowledging that it "need not always be followed impartially," and that "morality thus allows us to exhibit our beneficence with partiality in regard to those with whom we have *special relationships*." (Beauchamp & Childress 2001:168, own emphasis). The assumption and importance of the personal relationship especially emerges when concerns are raised regarding the introduction of market mechanisms in the delivery of healthcare that would result in "depersonalizing patient relationships" (Werhane 1990:8), and that, "privatization destroys the physician-patient relationship by converting altruistic care-givers into profit-seeking business people" (Buchanan 1995:221). In contrast, while it may be true that organisational ethics should not necessarily only be concerned with economic responsibilities, it is evident that the nature of the relationship between funding organisations and their subscribers lacks this personal aspect since the, "organization's primary relationship to its patients is that of an insurer to an insured, not of a health care provider to a patient. (Mariner 1995:240).

3.2.2 - Commodification of Healthcare

The second reason for the apparent incompatibility between healthcare ethics and organisational ethics is that the latter is specifically concerned with the exchange of commodities and there is some doubt whether healthcare qualifies. However, it should be noted, that since a commodity can generally understood to be any product or labour that can be bought or sold, the concern with healthcare as a commodity is not whether it can be bought or sold, but whether it should be bought or sold and there are some arguments that suggest this is not ethically permissible. One view that supports this claim has already been suggested by showing that healthcare is by nature concerned with the personal

relationship between the healthcare provider and the patient which cannot be said to be true of other traditional market commodities. A second reason for questioning the characterisation of healthcare as a commodity recalls the discussion on the value of healthcare as an important social good, the claim therefore is that it is ethically questionable to only distribute this good based on one's ability to pay, or, by extension that the primary concern in healthcare should be to "achieve efficiency above all else." (Daniels 2001:4). Whether deemed to be of instrumental or intrinsic value, there is sufficient reason to claim that health, and by extension healthcare, is a necessary and important social good which implies that there are social obligations to protect and promote health and explains why in certain cases people can be entitled to more healthcare benefits than only those stipulated in private health plan contracts. The heterogeneous nature of healthcare is also suggested as a reason for why it cannot readily be commodified; "Heterogeneity of goods means that the utility derived from a good depends on the recipient and his or her condition." (Landwehr 2013:299), so if healthcare were only available through market exchanges then those who necessarily need it would have no means of access unless they could afford it, conversely, those with the ability to pay for healthcare could legitimately, according to an unrestrained free market view, purchase healthcare that is unnecessary or not necessarily valuable to them – in a world where these benefits are desperately needed and resources scarce this would be morally unpalatable.

These commodification arguments are specifically directed at the nature of healthcare but say little about the reasonable characterisation of medical skill as a form of labour that healthcare professionals may, and do, legitimately trade. Commodities, including labour, require just proprietorship or ownership and it is on these grounds that Pellegrino refutes this claim of medical skill as a form of commodifiable labour. He maintains, firstly, that the nature and importance of healthcare which promotes health or reduces the impact of disease means that healing is a special kind of human activity that differs from other forms of labour, "the universality, unpredictability, inevitability, and intimate nature of the assault of illness on our humanity, the impediments it generates to human flourishing, and the intimate and personal nature of healing give health care a special place even among the helping professions." (Pellegrino 1999:249). Secondly, he argues that medical skills cannot be considered proprietary or 'owned' by healthcare professionals for the following reasons: The acquisition of medical skills is not something that medical professionals can attain themselves, but relies on knowledge gleaned over many years as well as shared knowledge from the community and publicly funded research. This may however be said to be true of all forms of knowledge and skill transfer, the special nature of healing aside, the

implication that any skills or expertise gleaned from historical or public knowledge sources cannot be considered labour would eliminate virtually any form of work as a legitimate tradeable commodity. His third, possibly more effective, argument is an oblique appeal to social contract theory which posits "an implicit agreement between society and an artificial entity in which society recognizes the existence of the entity on the condition that it serves the interest of society in certain specified ways." (Hasman 1998:29); since society provides and permits the means for attaining medical skills, healthcare professionals are under an obligation to serve the interests of society in return. He supports this view by claiming that the way medical skills are attained would not be ethically possible without the implicit permission of society, so for example, the use of cadavers and on the job training on living people would be impermissible in any field besides healthcare. Such societal permission is granted conditional on healthcare providers using their skills to benefit society: "The privilege of medical and nursing education are permitted in exchange for the benefits society accrues from the assurance of a continuing supply of well-trained physicians and other health professionals." (Pellegrino 1999:251). While these arguments that healthcare is a special kind of activity and that the acquisition of medical knowledge creates a covenantal obligation to society seem reasonable, they do present a highly idealised view of the profession and the implication that clinicians cannot legitimately be remunerated for their services seems less reasonable and, "Although egregious sacrifices of patient welfare to profit are condemned, more mundane trade-offs occur commonly and without comment." (Andre 1999:289)

While a broad understanding of the dominant features in Healthcare Ethics as discussed above provides useful insights that are relevant to healthcare rationing, in themselves, they do not provide real guidance on how to ration and pay little attention to the distributional complexities. They do however show that there are greater concerns, and justifiable reasons, that healthcare distribution cannot only be subject to the ethical requirements that guide the moral behaviour of organisations.

SECTION 4 - HEALTHCARE ORGANISATIONAL ETHICS

A dominant question in business or organisational ethics is whose interests such organisations are morally obligated to serve. Furthermore, it is reasonable to suggest that because of the nature of the commodity they purvey, healthcare organisations and healthcare funding organisations are subject to different ethical constraints that generally inform non-health related organisations. While the veracity of this assumption deserves further discussion, it remains true that where healthcare organisations operate

in the private sector, they are still subject to the market forces so it is necessary to consider their ethical obligations within the context of business ethics.

4.1 - Shareholder and Stakeholder Capitalism

As an unfettered application of pure capitalist market exchanges is neither practicable nor feasible, so is it that an unalloyed economic focus on maximising profits for shareholders cannot be the only moral obligation of an organisation; at the very least some moral minimum is necessary, albeit only to act legally (Winfield et al. 2014:102). This relatively minimalistic moral view of organisational ethics, termed the Shareholder Primacy model, denies that an organisation has any further moral obligations beyond increasing its economic value within whichever rules and regulations govern the industry. Though Medical Schemes are non-profit organisations they do operate within the private sectors and have specific obligations to all the participants of the scheme who, through the financial contributions they make to the scheme, may be regarded in the same way as shareholders or owners would be in for-profit organisations. So while schemes may not have obligations to shareholders as traditionally defined, they do have similar obligations to guard and responsibly distribute the funds entrusted to them; this obligation of stewardship (to protect the risk pool and limit liability for the entire population by ensuring that the entrusted funds are legitimately used) is properly understood as an economic, not social obligation. Applying a minimalistic account of organisational ethics may, in the local context, therefore be taken to mean that the duties of stewardship (constrained only by legislative requirements) are the sole obligations of these organisations.

Whether this Shareholder Primacy model is a legitimate view of organisational ethics or not, it is this conceptualisation of organisational ethics that underlies the opposition to the corporatisation of healthcare delivery which claims that "the entry of profit-seeking enterprises has undermined the very care of ethical and just health care delivery," and, "when cowboy capitalism[9] is applied to health care, its noble cause of healing and caring for the sick becomes much less noble." (Gilmartin & Freeman 2002:53). Generally the literature on organisational ethics, especially when related to the healthcare sector, maintains that those opposed to the application of market mechanisms misinterpret or misunderstand the market with their claims that, "a form of economic egoism has corrupted the health care system, replacing the caring and professional models with that of competing self-interests,

[9] Gilmartin and Freeman coin the term 'cowboy capitalism' to refer to a narrow view of capitalism that is only concerned with self-interest, greed, competitive advantage and incorporates the shareholder primacy tradition.

encouraging greed, confusing professional interests with profit, depersonalizing patient relationships, diluting benevolence and charity with a concern for economic viability." (Werhane 1990:8). According to Patricia Werhane, this is a misunderstanding of the foundations of capitalism as understood in terms of Adam Smith's classical economic theory which she argues is not solely motivated by self-interest and competition but that, "economic exchanges are not based merely on competition but on mutual cooperation and coordination." (Werhane 1990:13). Such apparent misreading of the objectives of capitalism aside, a broader and widely accepted ethical view of the moral obligations of corporations is the Stakeholder Model that "posits links between ethics and strategic decision-making by emphasizing a fiduciary relationship to stakeholders impacted by an action or that have the capacity to influence an action." (Bean 2011:321) and assumes that the organisation and all stakeholders (typically shareholders, customers, employees and the broader community within which the organisation operates) are a shared moral community. It is important to note that this model does not exclude the economic obligations of an organisation; it merely advocates that organisations should be subject to a broader set of obligations that consider the interests and wellbeing of all stakeholders whoever they may be. Some conceptions of the model acknowledge not only that all stakeholders have rights and interests that can be harmed or promoted by the organisation, but also that their interests are integral to the wellbeing of the organisation since stakeholders can be viewed as "those who are instrumental, one way or another, to the firm and its well-being." (Werhane 2000:173). What makes this specific understanding of the model interesting is that if the organisation's well-being (which can appropriately be viewed as economic well-being and longevity) is dependent on meeting the interests of the stakeholders, then the obligations espoused by the narrower shareholder primacy model could be extended to include this broader community. Nevertheless, even though the wellbeing of all stakeholders may ultimately result in better economic performance, the model is not necessarily defined in this way, but more commonly a "stakeholder theory provides understanding of organizations and organizational accountability that best integrates financial issues *and other considerations*." (Werhane 2000:170, own emphasis), thereby expanding the ethical obligations of organisations to include broader social issues. While stewardship obligations and contractual fidelity are both important and relevant organisational obligations, the more inclusive and accepted stakeholder model suggests that there are additional social obligations to all those whose lives are affected by the organisation and for healthcare funders these obligations would be directly related to the way health, as a valuable social good, is safeguarded by the organisation. It is this view of organisational ethics that provides an adequate rebuttal to the rationale that since these

organisations are merely funders, not healthcare providers, their obligations need not extend beyond those imposed by stewardship and regulation.

4.2 – The Free Market and Managed Care

More generally, the application of market mechanisms to healthcare delivery are defended by appealing to the benefits of free market exchanges that, have "an almost-magical ability to achieve economic efficiency, primarily because of the voluntary nature of exchange and the existence of competition amongst producers." (Winfield et al. 2014:75). The idealised view of the competitive market is that since consumers can freely and autonomously choose and change their 'purchases' to meet their needs, a competitive system will result in improved quality and services, reduce waste and excessive use of resources which in turn will reduce costs for consumers and encourage organisational innovation. So, "Through the usual mechanisms of competition a "quality product" should emerge since providers will compete with each other in quality, price, and satisfaction of consumers to keep their market-share and/or profits." (Pellegrino 1999:244). An argument could therefore be made that the application of free market mechanisms can adequately inform the ethical requirements of an organisation since it both attends to its economic obligations while ensuring that the needs of the consumers are being met through, "fair exchange, honest dealings, and keeping one's agreements in good faith." (Morreim 1995:249).

In the healthcare funding industry the free-market goals are ostensibly reflected in what has been termed 'Managed Care' which is, broadly, a system universally employed in the private healthcare industry that aims to achieve efficiency by managing the distribution of healthcare in a way that contains escalating healthcare costs, ensures quality health care services and controls perceived wastage in the system; it can be regarded as the operational system of limit-setting and the embodiment of population-centred rationing as, "the very nature of managed care requires allocating resources for the benefit of all members of a group." (Mariner 1995:242). There is currently no decisive, accepted definition for managed care though the multiple definitions publicised by specific MCOs all include elements of cost containment, waste management and are generally concerned with ensuring quality healthcare delivery (see Rimler & Morrison 1993). The South African Medical Schemes Act defines managed care as: "clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is

affordable, through the use of rules-based and clinical management-based programmes." (MSA Chp.5.15).

The managed care model receives wide criticism and often understood only as an economic tool designed to prevent adequate or equal access to healthcare: "The potentially immoral nature of managed care is highlighted when its processes focus on economics, cost containment, and profit at the expense of appropriate quality, the integrity of professionals, and the primacy of autonomy of patients." (Gilmartin & Freeman 2002:55). The perceived violation of respect for autonomy occurs on several levels: Firstly, given the limitations and restrictions that it necessarily imposes once members have entered into a contract with the organisation; secondly, because the health plan contracts are obscure and difficult to understand it is questionable that subscribers are able to exercise real autonomy; and finally, the limitations are said to restrict the autonomy of healthcare professionals and hamper their ability to heal patients.

4.2.1 – Consumer Autonomy

Once a person has chosen a health plan, further healthcare choices are limited through managed care mechanisms that may include capitation agreements with selected service providers, limitations on types of conditions that will be covered and the use of formularies. While consumer choice and voluntarism may occur when selecting which healthcare funding organisation and health plan people select, once they have entered into a contract, their choices regarding healthcare providers and types of treatments are restricted by these managed care mechanisms and this is often criticised for being a violation of respect for autonomy. Proponents of managed care deny this to be true by arguing that since an initial choice *has* been made, when a funder applies these limitations it is, "acting in accord with autonomous choice of the patient, he or she is acting in such a way as to fulfil the patient's autonomy," and, "Thus, the ethic of managed care is but a part of the age of respect for patient autonomy." (Waymack 1990:76). Furthermore they suggest that, in line with the business principle of *caveat emptor,* as long as the seller has not concealed any relevant information, the consumer is responsible for and accepts the risks associated with their purchase so, "patients must live (or die) with their choices – that is, what the health plan contract provides." (Mariner 1995:240). These rationales do however seem to fail in the healthcare funding industry since it can be shown that subscribers often have little choice regarding which plans are available to them and, even when they do, changing to different plans is administratively burdensome,

financially questionable and may not succeed in improving their access to healthcare when they need it most.

The assumption of autonomous choice is firstly questionable on the grounds that many consumers have their health plan choices made by their employer. While this concern is more commonly associated with health insurance in the United States, the results from a recent healthcare consumer survey[10] revealed that in South Africa, "50% of respondents who have ever been on medical aid had selected their medical schemes through their employer." (CCSA(1) 2016:7). Furthermore, certain Medical Schemes[11] restrict access, so even if consumers would choose to participate in one of these schemes, they are prevented from doing so since for these, "membership is reserved for a select group of individuals such as employees of a certain industry, organisation, association or union." (CCSA(2) 2016:2). Nevertheless, the objection on these grounds may be less worrisome where employers are the actual purchasers of a given health plan and the choice has been made at an organisational level; though claiming that individual autonomy is respected in these cases may require that participation in the organisation's chosen plan is not mandatory. The second problem regarding compromised autonomy is that even where choices are not necessarily determined by one's employer, changing or altering a health plan is administratively burdensome and has financial implications, this is supported by the results of the CCSA survey which revealed that the prevailing reasons respondents would not switch schemes was because of the "administrative difficulties and the fear of losing medical savings." (CCSA(1) 2016:12). More significantly however is that changing to a different plan type, while possible, has implications on access to healthcare benefits. Since plan limits will only be encountered once illness occurs and "it is often difficult to know what particular kinds of treatment are covered until a patient gets sick and needs specific services." (Mariner 1995:241) so subscribers may wish to change their plans only at this stage. However the imposition of waiting periods on new subscribers which specifically exclude pre-existing, known medical conditions for a defined time period, means that they would have little or no access to necessary healthcare cover at the time of need[12].

[10] Conducted by the Competition Commission of South Africa (CCSA)
[11] Termed either Closed Schemes or Restricted Schemes
[12] It should be noted that while applying waiting periods may limit choices, it is an absolute and justifiable requirement which enables healthcare funders to mitigate against the risk of incurring significant financial burdens were members permitted to join a scheme only when they are ill and in need of expensive medical treatments at comparatively lower contribution rates.

In addition to the concerns regarding the limited range of options and accessibility of cover, voluntarism is also questionable given the asymmetry of information that typifies the industry where, "customer sovereignty…is limited in healthcare due to information asymmetry as well as psychological vulnerability that undermines the decision-making process." (Nunes et al. 2009:260). The relative information, and associated power asymmetry, between patient and healthcare provider is assumed and generally accepted in medical ethics which "assumes significant inequality in knowledge and skill between physicians and patients," so, "For this reason, physicians have been found to have a type of fiduciary obligation to their patients." (Mariner 1995:238). This imbalance, amplified when people are rendered more vulnerable though illness, may generate additional moral responsibilities for healthcare providers that organisational ethics cannot adequately accommodate since there is no analogous assumption or acceptance of information asymmetry in the market where, "fair competition assumes some measure of equality among those who do business" (Mariner 1995:238). Nevertheless, the complexity of healthcare funding contracts and the associated asymmetry of information is a common concern that weakens the claim that subscribers exercise autonomous decision-making since, if the constraint to respect autonomy is not limited merely to what someone does not want to consent but to "doing something to which the other *cannot* consent." (O'Neill 1993:178-179), then an inadequate understanding of the contracts suggests that consent is dubious. The "convoluted obscurantist language of the contract" (Pellegrino 1999:257) aside, the consensual argument is also questioned on the grounds that the knowledge a person *can* have of their potential healthcare needs is limited and, "we have much greater trouble anticipating our needs for health care if we have no obvious history of problems," (Daniels & Sabin 1997:310). This is one way in which healthcare needs are dissimilar to our needs for other types of commodities attained through fair market exchanges and further undermines the validity of commodifying healthcare. Therefore since, "much of the information necessary for a rational choice is not available when the choice must be made." (Mariner 1995:241), the market assumption of equality between those who do business is questionable in this context and the argument that healthcare funding contracts respect autonomy because they are voluntarily entered into is equally questionable.

A response to this concern regarding the complexity of healthcare contracts and its implication for consumer autonomy is that it could be addressed if funding organisations provide "better consumer education in this area so that patients and surrogate decision makers might become more informed about the actual affects [sic] of treatment choices on patients, their families and the community, including realistically expected outcomes and financial costs." (Cummins Gauthier 2002:278). While

improved communication and consumer education could improve the asymmetry problem, it remains unlikely that these contracts can be made completely comprehensible or comprehensive. Nevertheless, it would be implausible to suggest that the contracts be eliminated from the industry, they are essential tools for almost any business enterprise and in private healthcare funding they are necessary to "establish what services or reimbursements a patient can expect in return for a premium payment." (Morreim 1995:249). Furthermore, even though there may be legitimate concerns regarding the consumer's ability to exercise these types of choices with perfect autonomy, it would also be mistaken to claim that they enter into these contracts in complete blind ignorance. At the very least consumers should understand that they have willingly chosen to participate in a cooperative, risk-sharing scheme of a specific organisation, that that organisation operates within the private industry and that, even if they are unclear on the exact details, there will be limits on what healthcare benefits they have access to. However, assuming that the contracts are themselves fair and legitimate, the parties' fidelity to the terms and conditions of the contract is probably more a legal than an ethical concern; and, because these contracts cannot conceivably include all health potentialities, other ethical considerations should be considered when determining how to deal with these unavoidable contractual gaps – gaps that can generally be construed as micro-level issues.

A final, more general concern regarding consumer autonomy needs mentioning: often participating in a cooperative healthcare funding scheme is in itself not necessarily voluntary for most people and, while it may not qualify as a traditional desperate exchange in terms of preying on the weakest and most vulnerable in society, if "the means for modern health care can only be raised collectively." (Heubel 2000:250), then the mere act of purchasing a health plan is less a voluntary choice than a fundamental necessity to ensure adequate access to quality healthcare and to provide financial risk protection for potentially disastrous healthcare costs.

It remains a legitimate concern that since health care plans are not readily fungible and the contracts that govern them are unavoidably complex and incomplete, there are valid reasons to claim that respect for consumer autonomy is compromised when health plans are selected and, by extension, when the terms of these contracts are strictly applied. These concerns may however not be sufficient to make the claim that organisations and consumers should not be bound, both legally and ethically, to the conditions of these agreements since, according to Haavi Morreim, if contractual requirements are improperly applied it would be unfair to the population and potentially undermine the stewardship

obligations of the organisation so, "ignoring contractual limits, even out of compassion, can disserve not only the payer with whom the patient has contracted, but also all its other subscribers."(Morreim 1995:250). However, where there are specific omissions or the contract stipulations can be shown to be unjust then ethical deliberation and decision-making is required that "must consider not just the individuals requesting coverage, but also the answers' implications for other subscribers." (Morreim 1995:250).

4.2.3 – Managed Care and the Physician

Another equally legitimate concern regarding managed care is the implication of the model on physicians and other healthcare professionals. While it can legitimately be argued that, unlike the customers of other types of businesses, "patients, the consumers of healthcare services provided by HCOs[13], have a privileged status among stakeholders." (Werhane 2000:178), it does not follow that the interests and obligations of other stakeholders may be dismissed or subjugated. The restrictions imposed by managed care, and by healthcare rationing in general, receive significant opposition from the healthcare provider environment who view these restrictions as conflicting with their ethical obligations as well as hindering their autonomy: a review of physician surveys related to managed care showed that in general healthcare professionals believe that managed care negatively impacts both their ability to provide healthcare and their careers, and that it, "increased their cost of practicing medicine, strained relations with their patients and their colleagues, lowered their fees, and, in some cases, contributed to worse care for their patients." (Christianson et al. 2005:662). Respect for the autonomy of healthcare professionals should be a significant concern for funding organisations not merely because it acknowledges the professional integrity and expertise that "gives to that person or group of professionals normatively grounded powers." (Werhane 2000:174), but also because, unlike organisations, the personal nature of the patient-physician relationship and the associated ethical obligation of healing, mean that they, not the organisation, are directly responsible for their patients' healthcare needs. Some managed care organisations may deflect objections to their perceived undermining of physician autonomy on the grounds that they are only responsible for funding decisions, not actual healthcare provision; however, given the current costs associated with certain treatments, especially those with catastrophic health implications like cancers or motor neuron diseases, declining funding is equivalent to declining medical care and such equivocation would be an eschewal of ethical

[13] Health Care Organisations

obligations beyond stewardship. The implication for healthcare funders is that, while it may be legally acceptable for them to strictly adhere to the terms and conditions of the contracted agreements and the associated limits imposed by managed care mechanisms, such strict adherence may be challenged on ethical grounds and the mere application of a market or corporate ethic is arguably an inadequate ethical framework for these types of organisations.

4.3 – Conflicting Paradigms: Healthcare Ethics vs. Healthcare Organisational Ethics

The ethical concerns related to managed care and the obligations imposed by contracts sharply illustrate the conflict that exists between healthcare ethics, or bioethics, on the one hand and organisational ethics on the other which can be summarised as follows: "Society seeks to allocate services as efficiently as possible, whereas patients and physicians seek to optimize individual patients' care. Decision-making from one perspective conflicts with decision-making from the other perspective, creating tensions and inefficiencies." (Beauchamp & Childress 2001: 262). While it may be true that hostile healthcare ethicists may focus on only the worst types of business practices, dismissing the conflict between the two frameworks merely on the grounds that the nature of organisational ethics is misunderstood or that it could be resolved by appealing to the ethically broader stakeholder model, grossly underestimates and minimises the depth of the conflict. The "schism in the values of professional providers and the amoral nature of efficiency-maximising, profit-orientated business enterprise" (Gilmartin & Freeman 2002:54), may, in part, be attributable to broader institutional parameters that dominate each field If it is true that, "when caring for a patient, the physician should have *only* the welfare of that individual patient in mind. The question of *finance* should never be allowed to deter the physician from recommending the most medically appropriate of the alternatives. This loyalty to the individual patient is part of what is seen as the special obligation of the physician as a *professional*." (Waymack 1990:69), then healthcare ethics permits, or even requires, a partiality of care. Healthcare funding organisations, on the other hand, can rarely, if ever, justify partial treatment of certain individuals based on similar relational grounds or morally arbitrary factors like, for example, status. In addition the principle of beneficence is widely considered an essential component of bioethics and is, according to Beauchamp & Childress, the principle that permits healthcare providers to favour those with whom they have a this specific relationship. Such beneficence is however not considered a traditional requirement of business and explicitly excluded from Adam Smith's classic capitalist conception which maintains that, "It is not from the benevolence of the butcher, the brewer or the baker that we expect our dinner, but from their regard to their own self-interest." (Smith 1985:5). While it may be argued that organisations should act

beneficently, the comparative impersonal nature of institutions suggests that "these, impersonal institutions, policies or management guidelines cannot be expected to perform in the same [person-to-person] fashion. They cannot obviously reach the patient in the same way or exhibit similar specificity of concern" (Kaldis 2005:39). Thus it could be assumed that there is no beneficence imperative for organisations that permits partiality but there is a much stronger injunction against unfairness; furthermore, since private healthcare funding organisations are cooperative schemes that all participants contribute to, the requirements of impartiality and consistency that support fairness are core obligations that should be at the forefront of their organisational ethic. So, while it is justifiable to claim that healthcare should not be held ransom to one's ability to pay, the insular position that some healthcare ethicists advocate, erroneously suggests that organisational ethics is, at worst, only concerned with profit-seeking and, at best, unable contribute any valuable insights to healthcare needs. More concerning however is that their dismissal of the very real fiscal and resource constraints means their contribution to finding an ethical solution to healthcare resource allocation is negligible at best.

It seems reasonable to suggest that given the specific nature of health as an important social good, healthcare organisations may be subject to more than the general ethical constraints that apply to organisations in other private industries[14]. While the stakeholder model may provide a more acceptable ethical framework for corporations than the 'cowboy capitalist' approach, it is too generic to adequately address the specific ethical requirements of organisations responsible for supporting and promoting health: "Where private organizations distribute a fundamental good on society's behalf, as in the case of health care, simply behaving like a responsible corporation that meets high but ordinary ethical standards is not enough. By itself, the standard is insufficient to assure justice" (Daniels & Sabin 1997:313). The implication is not that these organisations are necessarily subject to a *higher* moral standard than other businesses; only that there are additional moral requirements that add layers of complexity to decision-making that cannot easily, or even necessarily, be resolved by merely by appealing to the principles that govern either healthcare or corporate ethical accounts.

[14] It would not be unreasonable to suggest there are similar extended obligations in education.

SECTION 5 - ACCOUNTABILITY FOR REASONABLENESS

> "There is reason to believe… that general principles of justice and general characterisation of the goals of medicine cannot really address the problems of setting priorities in ways that satisfy our moral concerns in particular cases…Rather, we must agree on how to make the practical decisions about limits that arise." (Daniels & Sabin 1997:324)

Norman Daniels and James Sabin's Accountability for Reasonableness (AFR)[15] is the most widely recognised procedural account for addressing the healthcare rationing problem and to date several countries including the UK, Canada, UK, New Zealand, Sweden, Denmark and Norway (Nunes & Rego 2014, Sabik & Lie 2008) use some form of AFR for making healthcare rationing decisions. As stated previously, the scarcity of healthcare resources means limit-setting is essential and a fair and legitimate way to ration these resources can therefore be considered a requirement of justice. However since there is no consensus on the right way to ration, and since the "consensual model fails in our health care system and, further, that we have a social obligation to ensure that the private sector of our health care system delivers health care fairly," (Daniels & Sabin 1997:306), they believe it is necessary for organisations to be held publicly accountable to ensure this obligation is met. They therefore suggest that the focus of the healthcare allocation debate should shift from broader indeterminate or impractical ethical theories to a procedural account because, "when we lack consensus on principles that tell us what is fair, or even when we have general principles but are burdened by reasonable disagreements about how they apply, we may nevertheless find a process or procedure that most accept as fair to those who are affected by such decisions. That fair process then determines for us what counts as a fair outcome" (Daniels & Sabin 2008:4). If a decision making process is seen to be transparent, consistent and based on relevant reasons then the outcomes could reasonably be considered legitimate and fair. The stated central thesis for AFR is that "reasons or rationales for important limit-setting decisions should be publicly available," and that these, "must be ones that "fair-minded" people can agree are relevant to pursuing appropriate patient care under necessary resource constraints." (Daniels & Sabin 2008:44) and sets out four conditions that must be satisfied for limit-setting decisions to be considered legitimate and fair: The Publicity Condition, the Relevance (or Constraints on Rationales) Condition, the Revision and Appeals Condition, and the Regulative (or Enforcement) Condition. Daniels & Sabin do not claim that AFR will eliminate all the moral disagreements surrounding limit-setting decisions but rather

[15] Or A4R in some texts.

that it is a tool that can, "narrow the scope of controversy and the methods for adjudicating them." (Daniels & Sabin 2008:44). The goal of AFR should therefore not be understood as an attempt to resolve the moral conflicts surrounding difficult limit-setting decisions, but as a framework that, if appropriately and consistently used, improves the ethical rigour applied to healthcare decision-making so while they acknowledge that decisions may remain controversial the intention of AFR is to make, "decision makers accountable for the reasonableness of their decisions. [The four conditions] provide conditions for the legitimacy of controversial decisions." (Daniels 2008:25).

5.1 – The Four Conditions

5.1.1 - The Publicity Condition

> "Decisions regarding both direct and indirect limits to care and their rationales must be publicly acceptable." It "requires openness or publicity; that is, transparency with regard to the reasons for a decision." (Daniels & Sabin 2008:45/46)

The Publicity Condition requires that the underlying reasons and rationales for limit-setting decisions be made publicly available to all affected by these decisions where those affected should be understood include to all patients (or members), clinicians and potential subscribers since, "one assumes they are not applying this expectation to actual patients who have had their treatment denied, but are referring to the population affected by priority setting decisions, prior to the need for treatment arising, as is commonly accepted in the broader philosophical literature on collective prioritisation." (Ford 2015:225). This transparency about the reasoning for decisions will demonstrate the "coherence and consistency" of the policies and, "demonstrate that there is a commitment to an even-handed appeal to reasons and principles, so that relevant similarities and differences in particular cases are recognized and attended to." (Daniels & Sabin 2008:47). In making the rationales publicly accessible and providing a record of the decisions, decision-makers could be held accountable for these decisions and would accordingly be required to justify decisions that deviate from their declared reasons and rationales.

Daniels & Sabin claim that the Publicity Condition is analogous to the case law model so in building a visible record of previous decisions, "The considered judgments reflected in past decisions constitute relatively fixed points that can only be revised with careful deliberation and good reasons…there is a commitment to coherence in the giving of reasons – decisions must fit with each other in a plausible reason- and principle-mediated way." (Daniels & Sabin 2008:48). Since, according to them, case law

requires transparency and consistency the requirements of fairness (that similar cases are treated similarly except where relevant reasons permit differential treatment) and of impartiality can be met. Further virtues of the case law model is that it leads to "more efficient, coherent, and fairer decisions over time", "reflects a commitment to continue to act on the cited reasons and rationales in future similar cases", "improves the quality of decision making" and "promotes thoughtful evaluation of these reasons." (Daniels & Sabin 2008:47-49). Finally, they suggest that voluntary compliance and acceptance of decisions is more achievable if reasons are provided since this would be "a way to show respect for persons" (Daniels & Sabin 2008:52).

Since making reasons and rationales publicly accessible necessarily requires that they be formalised and documented the condition also serves to make them more concrete and comprehensible for the decision-makers themselves, thereby guiding them to be more deliberate and rigorous when considering cases; therefore even if decisions could be considered intuitively just and legitimate, the Publicity Condition would provide more than these somewhat nebulous appeals to intuition. Moreover, since these decisions are exposed to public scrutiny, the Publicity Condition is a important to tool for ensuring decision-makers consider *all* relevant reasons, values and principles and are be accountable for the decisions they make. If decision rationales are not publicly available there would be no demonstrable accountability or record of consistency, and decision-makers would have no compelling reason to consciously avoid partiality and self-interest. "Only by being explicit about reasons will it be possible for MCOs to demonstrate that the solutions they adopt to coverage under resource constraints reflect a pattern of reasons and principles that all affected by these decisions must take seriously." (Daniels & Sabin 1997:329). In addition to compelling decision-makers to be demonstrably committed to decision rationales, a further benefit is that if potential subscribers to the organisation have access to these reasons, their ability to make informed decisions when selecting plan options will be enhanced; in this way the organisation can be shown to visibly and actively respect the autonomy of their customers.

For the most part, the Publicity Condition is not particularly controversial and some commentators even suggest that AFR is not public to ensure legitimacy and that, "By involving multiple viewpoints early on and sorting out what the disagreements will be before the initial decision is made, disagreement can be minimized and the process can be improved." (Sabik & Lie 2008:83). While this concern regarding the lack of public participation is more relevant in the public arena there are some objections to the Publicity

Condition that are applicable to the private sectors context; including compromising the organisation's competitive edge, possibly violating patient confidentiality, and the potential for moral hazard.

Since private healthcare funding organisations operate within the competitive market system, in South Africa, where the industry is highly regulated and private healthcare expensive, competitive opportunities are limited because many plan benefits are legislatively prescribed and pricing is restricted by the already high costs of healthcare. Reasons and rationales for how and why organisations make specific funding decisions could therefore legitimately be considered a type of intellectual property that contributes to its competitive edge. However, since one suggested rationale for the Publicity Condition is that "there may also be demonstrable market value to having a visible record of commitment to patient-orientated decision-making." (Daniels & Sabin 1997:325), it is possible that an organisation that can show it is committed to important principles and values, and that applies these consistently and impartially may, in this way, acquire greater competitive advantage than what may be obtained from hiding these rationales.

While the concern for publicising possible intellectual property may be addressed by suggesting that visible ethical practices may be more advantageous to an organisation, there is no readily available answer for the second concern which suggests that "The public interest in publicity may conflict with the applicant's privacy interests and claims to confidentiality." (Jonas et al. 2014:827). Patient confidentiality is a cornerstone of the healthcare industry and considered inviolate; since micro-level decision making is required for exceptional cases the distinct features of these cases can be fairly specific; even if the patient's personal details were scrubbed from the record, the discrete details of a case may be sufficient to trigger recognition and violate the obligation to protect patient privacy. Even if the Publicity Condition as described by AFR only explicitly seems to require that underlying rationales and reasons be made public, Jonas et al. argue that this is not the intent of AFR and that more information is essential since, "A list of decision-making criteria indicates what considerations decision-makers regard as important but, without some further explanation, provides little illumination about how criteria are understood by decision-makers, applied to specific funding decisions or prioritised when there is a conflict." (Jonas et al. 2014:828). Furthermore, it would be difficult to demonstrate the consistency and impartiality if specific decisions were not available to support such claim. It would however be unrealistic to expect patients to waive their right to privacy under these circumstances and ethically unjustifiable to make this a requirement for assessing their cases. Applying the Publicity Condition may therefore need to be limited

to the underlying reasons and the application of a form of case law methodology may need to be revisited unless protections can be guaranteed. While this might compromise a public claim of consistency, proper governance of the decision-makers and the institutional design of the decision-making body may be sufficient to ensure that impartiality and consistency are observed.

The final concern with the Publicity Condition is the potential for moral hazard or 'gaming' the system in that "Published decisions could arm applicants with the means to finesse claims" (Jonas et al. 2014:829). If people are made aware of the underlying reasons and rationales for decisions they could adapt their requirements to ensure that their cases are approved. While it would be incorrect to suggest that all people fundamentally lack integrity and would necessarily behave in this way, deception and misrepresentation in the healthcare insurance industry is not uncommon; studies have "shown that in many circumstances physicians are willing to deceive insurers to obtain specific health care benefits" and that there is not insignificant public support for such deception (Werner et al. 2004:53). However, knowing the way decisions are made will only render the scheme vulnerable if false or fraudulent information is provided and there are legal mechanisms in place that are designed to curtail such behaviour. In addition, insurers can mitigate such abuse by having access to all relevant medical information and investigations as well as having recourse to review cases by appealing to independent clinical specialists who would be most suited to provide expert feedback on the validity of these requests. An additional consideration that suggests that the details be made available despite the potential moral hazard is that, "An application's prospects may be enhanced by outlining relevant similarities with previous applications," which, "is no threat to the fair workings of the decision-making process." (Jonas et al. 2014:829); this may further enhance the legitimacy of the process since it would ensure that all subscribers have equal access to discrete deliberation and decision-making for similar cases that they would otherwise believe are legitimately declined because they are unable to effectively interpret their health plan contracts.

5.1.2 - The Relevance Condition

> "The rationales for limit-setting decisions should aim to provide a *reasonable* explanation of how the organization seeks to provide "value for money" in meeting the varied health needs of a defined population under reasonable resource constraints. Specifically a rationale will be reasonable if it appeals to evidence, reasons, and principles that are accepted as relevant by fair-minded people who are disposed to finding mutually justifiable terms of cooperation." It

> "sets constraints on the kinds of reasons that can play a role in the rationale; it recognises the fundamental interest in finding a justification all can accept as reasonable." (Daniels & Sabin 2008:45/46)

The Relevance, or Constraints on Rationales, Condition is the most interesting and most controversial of the four conditions and it has been suggested that AFR, "uses the relevance condition to introduce a substantial criterion through the back door." (Landwehr 2013:304). Some suggest that without it the "framework is nothing more than a demand for transparency and some degree of responsiveness to internal inconsistencies and external dissent." (Friedman 2008:104); whereas others suggest it "is not fit for purpose and is redundant to the accountability for reasonableness framework." (Ford 2015:227). Since relevant reasons need to be specifically concerned with providing value for money; this condition is concerned with the same issues that make rationing necessary: a scarcity of healthcare resources. Daniels and Sabin also refer to this condition as the Constraints on Rationales condition since it imposes constraints on the types of reasons and rationales that may be used to argue for the legitimacy of decisions, so while the publicity condition is lexically prior to the relevance condition, it seems that this second condition is logically prior to the first as these are the reasons that one expects they mean to be published. While there is specific reference to AFR being applicable to decision-making in cooperative schemes, the construal of reasonable goals cannot merely be based on the goals of the institution making the decisions; a goal can only be deemed reasonable "if it appeals to reasons, including values and principles, that are accepted as relevant by people who are disposed to finding ways of cooperating with each other on mutually acceptable terms." (Daniels & Sabin 2008:51). If the provision of reasons required by the publicity condition is a way to show respect for persons, this respect should also be reflected in the types of reasons which are properly and appropriately cognisant of moral pluralism and should "respect the moral diversity of those affected by the decisions," so, "Not just any kind of moral reason, compelling as it might be to the decision-maker (or the patient), will command recognition of its appropriateness or relevance from those affected by the decision." (Daniels & Sabin 1997:330).

The Relevance Condition specifies that these reasons must be those that 'fair-minded people', who are specifically located in situations that require mutual cooperation, "can agree are relevant to pursuing appropriate patient care under necessary resource constraints." (Daniels & Sabin 2008:44). Their explanation of who or what type of people qualify as fair-minded is done through a sports analogy: these are the people, "who want to play by agreed-on rules." (Daniels 2001:12), and accept, or reasonably seek

to change, the rules of the game "that promote the game's essential skills and the excitement their use produces." (Daniels & Sabin 2008:44). In addition, while fair-minded people may agree on the rules, they may disagree on the application of these rules so while controversy may not be completely eliminated, the initial agreement on the rules does "narrow the scope of controversy and the methods for adjudicating them." (Daniels & Sabin 2008:44).

The explanation of what constitutes fair-minded people has been be criticised on the grounds that it is too indeterminate, defining "relevance by reference to the opinions of fair-minded people" without determining who these fair-minded people are or "by what criteria…these people judge relevance," (Landwehr 2013:304). A further concern with this indeterminateness is that it describes 'agreement' as a sufficient parameter which suggests that preferences, not ethical obligations, may be adequate to determine the reasons and, by extension, decisions based on those reasons. If the Relevance Condition is to have any substantive ethical weight, the requirements of how fair-minded people select the relevant reasons and principles should surely require more objective formulations than mere preferences or opinions and so, "in the absence of any objective way to assess fair-mindedness, the Relevance Condition effectively requires us to take a leap of faith to believe that none of those entrusted with policy making bring vested interests to the table." (Ford 2015:224). Even if the overall process can be shown to be legitimate, if it is not explicitly required that decision-makers have a reasonable understanding of the issues at stake, the legitimacy of the chosen rationales and the legitimate authority of the decision-makers is cast into doubt. The objection is however not insurmountable, if adequate institutional measures are put in place to preclude "major conflicts of interests [that] cause biases when choosing among equally just options," (Rid 2009:16) and that ensure that decision-makers, "consider viewpoints other than their own in an unprejudiced way, acknowledge flaws in their own reasoning, and be prepared to change their views when faced with superior reasoning." (Ford 2015:219), then concerns regarding the potential subjectivity and questionable authority may be mitigated. In the private healthcare funding environment the concern regarding legitimate authority may be less significant than in the public sector since, even though consumers may arguably have limited autonomy when selecting health plans, it is reasonable to suggest that they do understand that they are entrusting the selected organisation with their funds and, by extension, how those funds are allocated and distributed. In this way subscribers can be said to have ceded responsibility for these decisions to the institution and thereby conferred legitimate authority on those organisations to make healthcare funding decisions on their behalf. Furthermore, since these decision-making responsibilities are governed by formal

contractual agreements and legislative requirements that include that decision-makers be clinically qualified, organisations have legal and ethical obligations to select rationales and make decisions based on more than mere preferences or opinions.

The specific phrasing of the Relevance Condition does suggest that Daniels & Sabin do not intend to prescribe any specific conditions and it may be argued that it is "a strength of accountability of the reasonableness model that it can be adopted for use in different contexts." (Ford 2015:212). However, this lack of specification of the reasons and rationales is generally criticised and viewed as a weakness of the model. However, this lack of specification of the reasons and rationales is more generally criticised and viewed as a weakness of the model. Ford suggests that the inadequacy of the condition is clearly evidenced by studies that have shown that no institution using the AFR framework uses the relevance condition so, "Despite widespread adoption of the framework, use of the relevance condition remains conspicuous by its absence." (Ford 2015:218). Nevertheless, while these studies may have empirical validity, it seems implausible that any healthcare allocation decisions could happen without some underlying rationales, whatever they may be, and the assertion by such institutions that they do not apply the relevance condition may because they consider the rationing principles to be prior to and therefore not necessarily part of their specific application of AFR. For example, the NICE Charter[16], makes reference to amongst others, social values and equity, and clinical- and cost-effectiveness considerations which can all be understood as relevant reasons for their clinical guidelines.

While Daniels and Sabin have explicitly not defined a specific list of relevant conditions, some commentators suggest that given Daniels' seminal work on the value of health in terms of its contribution to the Rawlsian notion of fair equality of opportunity (FEO), "it is logical to interpret the idea of a fair and sensible explanation [reasonableness] as one which is consistent with Rawls' principle of fair equality of opportunity." (Ford 2015:218); this implies that relevant reasons should be understood as those that promote this end and objections to AFR are accordingly raised on these grounds. So while no specific reference is made to FEO in the description of the Relevance Condition (or the other three conditions either), "given that the AFR's Relevance Condition does not specify with regard to what principles or criteria reasons have to be relevant, there remains room for the suspicion that the principle of fair equality of opportunity eventually constitutes a hidden criterion of relevance in Daniel's account."

[16] https://nice.org.uk/Media/Default/About/Who-we-are/NICE_Charter.pdf

(Landwehr 2013:305). Hasman & Holm are less cautious with the assignation of FEO as the core underlying principle of the Relevance Condition, stating that, for AFR, "arguments that entail reasons which are aimed at rectifying or alleviating inequality of opportunity in the relevant population are reasonable arguments and should be allowed." (Hasman & Holm 2005:264), they claim that any arguments that are neutral or increase inequalities for opportunity are therefore unreasonable and should be excluded from the decision making process. While Daniels does in a later work acknowledge that, "the appeal to process is constrained by some prior moral principles. For example, an outcome should not contradict what fair equality of opportunity requires by discriminating against a subgroup." (Daniels 2009:38), it does not follow that this negates his view that general principles of justice, such as ensuring FEO, "is too general and indeterminate to help us make specific resource-allocation decisions." (Daniels 2008:24). Therefore while it is a reasonable and acknowledged objection that FEO is too vague to provide clear parameters for decision-making, it is questionable whether this objection can be raised specifically to AFR since, despite ample opportunity to do so, Daniels & Sabin never explicitly claim that ensuring FEO must be a relevant condition.

Daniels & Sabin do however provide some examples of the types of principles and reasons that should or should not be considered relevant but it seems clear that these are suggested as types of rationales and are not necessarily definitive or comprehensive. Accordingly they suggest that *mere* disadvantage cannot be considered a relevant reason since, because rationing is required due to resource constraints that cannot meet the needs of all claimants, someone will always be disadvantaged. For them disadvantage will only qualify as a relevant reason if two conditions are met: firstly, if the formal requirements of justice (that similar cases be treated similarly) are violated since this, "points to the morally objectionable arbitrariness in the outcome" (Daniels & Sabin 2008:44); and, secondly, that no one experiences more disadvantage than they would have under available alternatives. They also suggest that though even there, "there is considerable risk of being criticized for putting so direct a price on the value of life." (Daniels & Sabin 2008:55), the cost-effectiveness of a proposed healthcare intervention could be considered a relevant condition. They also exclude non-secular reasons as appropriate for healthcare decision-making. Though these three suggested types of reasons can be considered merely illustrative, Alex Friedman appeals to them to argue that there are no just grounds for the Relevance Condition since by limiting rationales, the model does not accommodate moral plurality. He claims that, "The condition is intended to screen out reasons grounded in particular conceptions of what is important in life, the paradigmatic case being that of religious faith." (Friedman 2008:108);

excluding non-secular principles, he argues, is an unjust restriction because it is questionable that faith-based world-views differ fundamentally enough from other comprehensive moral doctrines to sanction their exclusion: "In determining what types of health care services are of greatest value to people, their comprehensive view regarding what is important in life, be they religious, philosophical, or of any other kind, seem uniquely relevant." (Friedman 2008:108). Ford elaborates on the flawed assumption that others may reject faith-based reasons by pointing out that there is no evidence that people with different religious convictions (or none) would not support, for example, a Jehovah's Witness' "request for more expensive non-blood products over blood products." (Ford 2015:221). Friedman therefore maintains that AFR's constraint on the types of reasons is problematic since, if it is true that both people's fundamental comprehensive moral views as well as their religious convictions can be equally important, then there is no just way to limit the types of reasons that would be relevant and applying limitations on rationales involves imposing unjustifiable moral judgements, "since we live (and desire to continue living) in a pluralistic society, where presumably reasonable people hold different views on such matters as what life is all about, we should not utilize such views to adjudicate decisions that would be binding even on those who do not share them." (Friedman 2008:108).

Friedman also argues that AFR undermines the ethical and just concerns raised in the rationing debate, underestimates legitimate moral plurality and (questionably) claims that Daniels & Sabin, "suggest that we give up attempts to resolve our differences by finding principles or values that will yield the 'right' answers, and instead focus on putting in place procedures that will ensure fairness and legitimacy to whatever outcomes they generate." (Friedman 2008:102). He argues that there is no justification for limiting or constraining rationales and concludes that while AFR does provide for transparency and consistency in decision-making, the Relevance Condition should not be implemented because "the potential gains are dubious at best, and the costs, moral, political, and pragmatic, are far too high. Perhaps it is time to give up on the idea that we can simplify the task before us by entirely disallowing particular kinds or reasons and types of reasoning." (Friedman 2008:111). This version of the objection to AFR being unable to resolve rationing problems is a common concern with the framework and, even though Daniels & Sabin do not claim that their model will resolve the rationing problem, a recurring objection to the framework is this shortcoming which is generally attributed to the vagueness and lack of specificity of the relevant reasons and the condition's failure to provide guidance on how to weigh different principles. Accordingly, this deficiency in determining what would be legitimate or illegitimate

reasons is used to suggest that the Relevance Condition "is not fit for purpose and is redundant to the accountability for reasonableness framework." (Ford 2015:227).

In addition to these objections related to the apparent obscurity of fair-mindedness, what constitutes reasonable principles and whether one can legitimately constrain the types of reasons, the Relevance Condition faces yet another hurdle: the weighting problem – when different principles compete or conflict there is no readily available answer for which one/s should receive more weight or be prioritised. Not all commentators subscribe to Friedman's objection that there is no just way to specify principles but rather maintain that principles are essential to ensure just outcomes, "Explicitly and clearly discussing underlying principles as a part of the process can help to reach legitimate and acceptable decisions." (Sabik & Lie 2008:83). Daniels & Sabin acknowledge that, "There is no higher level agreement on how much weight to give competing values or principles." (Daniels & Sabin 1998:32) implying that they are aware that even once relevant reasons are identified, their framework does not offer any guidance on how to weigh and balance the different principles when making actual decisions. This objection to the Relevance Condition has specific implications on the formal requirements of justice since because the actual decision-makers in various institutions or cooperative schemes may reasonably weigh the reasons differently, the outcomes for the same cases may differ. Hasman & Holm consider that assigning weights to selected principles is as important as the establishment of the actual underlying principles since, in order to ensure consistency, organisations should also weigh and apply the principles in a consistent manner, "It seems that in order for the weighting to remain consistent (and hence reasonable) over time, the agreed weights must be made explicit and considered in conjunction with the reasons that are deemed relevant to priority setting." (Hasman & Holm 2005:265). The objection rests on the notion that if exactly the same information is presented but the process, depending on who applied it and how much weight competing principles are given, yields different results, then the requirement of formal justice are violated. Daniels & Sabin's response is that this does not present an actual flaw in their approach but rather that it is "a manifestation of an unavoidable moral uncertainty, which we must learn to respect and live with." (Daniels & Sabin 1998:38). Different outcomes, they also suggest, are more likely a result of different weightings of the principles, rather than actual disagreement on the principles and weighing principles differently is acceptable since this would be considered a "reasonable disagreement" (Daniels & Sabin 1998:38). They suggest that the specific circumstances of each organisation or institution could provide "a substantive reason or principle that grounds the decision" (Daniels & Sabin 1998:38), so a single case can thereby be rendered sufficiently dissimilar by

the circumstances of the institution to warrant different treatment thereof. Nevertheless, even if their response to the objection may be insufficient to invalidate it, they also maintain that a legitimate process is still preferable to "a lack of fair process and a kind of arbitrariness within an organization." (Daniels & Sabin 1998:39) and few would advocate that unsubstantiated arbitrary decisions in the context of healthcare distribution are ethically justifiable[17]. Furthermore, though it does not address potential inconsistencies between different institutions, they have claimed that one important benefit of the Publicity Condition is that it holds decision-makers accountable for how they apply the relevant principles and in this way the obligations of formal justice can be met. It is also possible that, were all these different institutions to apply AFR and make their decisions public, these different outcomes would be subject to public scrutiny and comparison; while this may not necessarily change an institution's behaviour, in a competitive market, they would be less likely to attract potential customers if their weightings (as well as their discrete underlying reasons) are unjustifiable or fail to reflect the reasonable moral commitments of subscribers.

This weighting problem is not unique to AFR: it plagues the rationing debate and has also made an appearance in the principlism model which responds by claiming that where principles conflict, on condition that the reasons are justified, balancing and specification can solve the problem. These conflicts are especially prevalent where decisions are required for high-cost cases that only offer limited clinical success. So for example, if cost-effectiveness and clinical success were relevant conditions, would it be justified to significantly deplete available resources if the chance of clinical success is marginal or the treatment could only guarantee a few additional weeks of life or only enhance the quality of life for those few remaining weeks. If not, then alternatively, could institutions ethically justify approving inexpensive treatments with similar or worse clinical outcomes. While AFR may not approach the weighting problem directly, the implied requirement of just ethical deliberation is prevalent in the framework and frequently referenced, "The arrangements required by the four conditions provide grist for the deliberative mill." (Daniels & Sabin 2008:63-64). The concept of deliberation is key for decision-makers in AFR: it is implied in the statement that *agreement* on the reasons is required by the fair-minded and furthermore, since these reasons "play a role in deliberation" (Daniels & Sabin 2008:58), it is a necessary requirement when dealing with dispute resolution, it is also explicitly a goal of the Publicity Condition to ensure that committee members are, "more sensitive to the ways in which reasons or

[17] The exception is those that suggest a lottery approach is the only fair way to allocate scarce healthcare resources.

principles they invoke sometimes conflict. Then they must engage in a difficult deliberation about how to resolve their conflicts." (Daniels & Sabin 2008:48). If deliberation is central to AFR and considered a potentially important mechanism for addressing the weighting problem it requires further discussion. An acceptable general characterisation of deliberative decision-making involves "a reciprocal exchange of arguments and aimed at both achieving a superior information base for decisions and solving, or at least managing, conflicts of value and interest." (Landwehr 2013:303)

Diego Gracia states that proper ethical deliberation is impossible when anxiety or emotions dominate decision making and that, "reducing problems to dilemmas is generally due to anxiety," he defines deliberation as, "weighing up the principles and values involved as well as the circumstances and consequences of each case, [which will] thus enable all, or at least most, of the possible courses of action to be determined." (Gracia 2003:230). While the implication that moral dilemmas are no more than anxious emotional reactions is highly questionable, he may be correct in the suggestion that a consultative process of ethical deliberation is an important analytical tool and, if entered into sincerely and with respect, may diminish the dominance of individuals' moral bias and self-interest in decision-making which, "can potentially serve to correct misunderstandings and turn superficial, myopic and self-centred judgments into more justified, farsighted and other-regarding ones," so that, "unwanted biases can at least partially be corrected within the decision-making process itself." (Landwehr 2013:308). However, understanding and showing the potential benefits of deliberation does not offer an explanation on how to weigh different competing principles and Gracia's proposed deliberation process, while too rudimentary to qualify as a comprehensive procedural account, provides some interesting and practical insights on how to approach the problem. His process, specifically designed for making healthcare decisions, requires that in addition to identifying and presenting the relevant clinical information of a specific case, the potential moral problems also be identified, analysed and any potential conflicts determined *as part of* the deliberative process. While this may seem axiomatic it is still worth stating; if decision-making incorporates discussions of potential moral conflicts as part of the deliberation process then the values and principles will receive more rigorous consideration and be appropriately addressed. "The primary obligation," according to Gracia, "is to comply with the principles and he/she who wishes to make an exception takes on the burden of proof, and therefore must prove that the exception may and should be made." (Gracia 2003:231). The interesting feature with this view is that it is not concerned with a complicated and potentially unresolvable weighting of principles, but rather that all relevant ethical principles are considered and where it proves impossible to apply certain

principles in particular cases, there must be clear and ethically acceptable reasons for doing so. A potential corollary of this view is that since the underlying reasons and rationales have already been determined to be relevant in terms of the ethical obligations of the institution, it may be possible to suggest that there should be an injunction on straightforwardly violating any principle.

Friedman's previous accusation that Daniels & Sabin suggest that principles and values be ceded in favour of procedures is a gross misrepresentation of the model if one considers the requirements and importance of the Relevance Condition to AFR. While the Relevance Condition does seem riddled with sufficient objections to justify his and Ford's views that it not be implemented, without it the substantive content of the framework is eliminated thereby weakening its potential normative force and ethical justification. Friedman's argument that there is no just way for "disallowing particular kinds of reasons and types of reasoning." (Friedman 2008:111), may be compelling, but it is equally valid to any of the rationales proposed in the broader healthcare rationing context. While this is not necessarily an effective response to this objection, it does suggest that it can provide little constructive content to the general rationing debate or to AFR specifically. Friedman aside, the major objection to the Relevance Condition seems to be the lack of specification (and by extension possible weighting) of the relevant reasons and principles which can potentially compromise the formal consistency requirements of justice. However, this objection does marginalise the intended objectives of both the Publicity and Appeals Conditions that buttress the Relevance Condition: "if limit-setting decisions must be made public and these decisions can be challenged, decision-makers presumably have an interest in treating similar cases similarly and justifying differential treatment – or at least inconsistencies are more likely to be caught." (Rid 2009:15). This particular objection may also possibly originate from the widespread need and an expectation for some resolution to the rationing problem so AFRs failure to dictate which principles are relevant is therefore construed as a failure of the framework. However, if one supports a reasonable and more moderate interpretation of the condition as being crafted in this way to provide flexibility for decision-makers to specify their own underlying relevant conditions based on their specific circumstances and obligations, then these objections are not as significant as their proponents may believe them to be. What does however require better clarification is the nature and requirements of those who are deemed 'fair-minded' and the implication that decision-makers can select the relevant conditions on less than ethically objective terms. Still, despite this lack of clarity of what constitutes fair-mindedness, what is clear is that selecting underlying rationales, reasons and principles as well as the actual decision-making

may not be done individually but through deliberation which, if properly done, may minimise the potential subjectivity.

5.1.3 - The Revision and Appeals Condition

> "There must be mechanisms for challenge and dispute resolution regarding limit-setting decisions, and, more broadly, opportunities for revision and improvement of policies on the light of new evidence or arguments." It "makes learning from experience and responding to disagreements a central component of decision making." (Daniels & Sabin 2008:45/46)

This condition is also referred to as the Dispute Resolution process and can be either an informal escalation process or a formal grievance procedure. It is designed to give those affected by the decision the opportunity to interrogate the legitimacy of both the outcomes and the decision-making process and, if they have not yet been presented, offer relevant arguments that may influence the decisions. In addition to providing such a platform, Daniels & Sabin believe this condition could further enhance the legitimacy of the decisions by opening them to broader public debate since "it engages a broader segment of stakeholders in the process of deliberation" (Daniels & Sabin 2008:58).

The plausibility of this condition is contingent on the first two conditions being met because only if the reasons and rationales have been determined and publicly accessible are, "people using the Revision and Appeals Condition to challenge a decision…able to understand the basis on which the decision was made." (Daniels & Sabin 2008:58). If these first two conditions are properly applied then, in theory, it is more likely that appeals to these decisions will be limited to ones related to the interpretation of the relevant reasons and contractual language, or to questions related to the available evidence (and providence of that evidence). This condition further enhances the credibility and transparency of the process, and may provide additional relevant reasons, so, "Where patients or clinicians use these procedures to challenge a decision, and the results of the challenge lead effectively to reconsidering the decision on its merits, the decision-making process is made iterative in a way that broadens the input of information and argument" (Daniels & Sabin 1997:340). In addition, they believe that if a robust internal dispute resolution procedure in place, there will be less reasons for people to resort to external authorities for further mediation of decisions.

No ethically substantive objections to this condition have emerged from the literature but Sabik & Lie suggest that the differences in the specific application of the appeal condition in real-world cases may undermine the validity of AFR. For example, Norway only permits appeals within a specified timeframe and not if treatment has been deemed unnecessary. The UK National Institute for Health and Care Excellence (NICE) will only permit appeals if the institute did not act according to the specified appraisal procedure, the decision was perverse in light of existing evidence or the institute has exceeded its powers, furthermore appeals on NICE decisions will also only be considered within 15 days of the decision being made. "The contention over the specific implementation of the appeal process," Sabik & Lie state, "shows how reasonable people with interest in the system will disagree about the procedures in place." (Sabik & Lie 2008:79). They claim that these differences in how the appeals process is applied demonstrates that AFR does not resolve the ethical tension between meeting patient needs and the financial stability of the health system and therefore that, "it is not clear that the concern for justice underlying the problem of rationing health care services will be addressed by such a procedural account." (Sabik & Lie 2008:82). While this objection, as well as concerns regarding the costs and labour involved in appeal processes, are valid practical concerns, they do not necessarily undermine the usefulness of the condition. In addition, as previously stated, Daniels & Sabin have not claimed that the AFR model is designed to resolve the rationing problem but to narrow the scope of the controversy so objections raised on these grounds may not be that substantial.

5.1.4 – The Regulative Condition

> "There is either voluntary or public regulation of the process to ensure that conditions 1-3 are met." It "puts teeth in the others." (Daniels & Sabin 2008:45/46)

The final condition requires that mechanisms are put in place to ensure that the other three conditions are met and thereby enforces the accountability of decision-makers in terms of following the tenets of AFR. Furthermore, if such governance is properly applied, it is an important condition that can support an organisation's claim of consistency and transparency. While the Daniels & Sabin express no preference for whether these regulations are imposed publicly or voluntarily by the organisations, they suggest that, in the absence of sufficient public regulation, internal regulation will show the organisation's commitment to legitimacy and fairness and give the public the assurance "that they are doing business with organizations that were actively addressing the fairness and legitimacy problems MCOs now face." (Daniels & Sabin 1997:343).

In the South African context Medical Schemes are highly regulated and subject to the conditions and regulations of the Medical Schemes Act. The regulations are comprehensive and include accreditation and administrative requirements, minimum care parameters (prescribed minimum benefits), permissible managed care mechanisms, oversight on benefit and plan changes and the requirements for accumulating and reserving 25% of membership contributions; even naming and changing the name of a medical scheme is subject to regulatory oversight. While this does not necessarily imply that additional internal regulation of decision-making is not important and may enhance its legitimacy, in the South African Medical Scheme context, decision-making can, with no added time, cost or labour requirements, meet the fourth condition of AFR.

5.2 - The Appeal to Proceduralism

While AFR may be considered the most comprehensive procedural account available in the healthcare rationing context, it is not the reason for the shift from appeals to normative ethical and distributive theories, "Given the propensity of questions of distributive justice to generate disagreement and the requirement that healthcare funding decisions be reached despite this, attention has been drawn to procedural justice as a necessary and fruitful pursuit for healthcare funding decisions." (Jonas et al. 2014:827). An adequate assessment of the plausibility and legitimacy of AFR (as an instance of procedural justice) should therefore consider the broader issues related to proceduralism before suggesting that it can provide better insight for healthcare rationing than straightforward appeals to abstract principles seem able to do.

One central question that dominates proceduralism is the following: even if a procedure can be shown to be legitimate and fair, does it follow that the outcomes it yields are equally legitimate and fair? One of the concerns regarding AFR, that it is invalidated because different decision-making bodies, faced with the same facts, may reach different conclusions, exemplifies this issue. This concern is rooted in the assumption that for a procedure to be considered legitimate and fair it must produce the same outcomes regardless of who is making the decision. However, in order for this to be considered a valid objection to proceduralism, it must be correct in this assumption that a just procedure can yield *only* one just outcome and this has yet to be proven especially if the background conditions within which the procedure operates can be shown to be just and where no criteria determining the fairness or legitimacy of the outcome exist. In addition, the possibility of multiple just decisions is in line with the notion that "reasonable people disagree…about the relative importance of several values or principles." (Daniels &

Sabin 2008:72) and that reasonable moral pluralism is acceptable and should be accommodated. Such acceptance of moral pluralism is defended on the grounds that it recognises the importance of autonomy to the extent that rational moral agents have the right to subscribe to and prioritise different ethical principles that are reasonable and justifiable. As the rationing debate has shown, while the prevailing accounts may overlook certain ethical concerns, the principles that dominate each are in themselves ethically defensible and none can be wholly dismissed. Nevertheless, while endorsing moral pluralism on the grounds of respect for autonomy may in itself be an important ethical consideration; the implication that all possible outcomes from a just procedure will be equally just, even if the background circumstances can be shown to be just, is questionable. Furthermore, even if it were possible to show that a procedure can legitimately produce numerous just outcomes, it does not necessarily follow that it *has* produced just outcomes. Another important consideration concerning proceduralism is whether procedures themselves can be viewed as just and legitimate irrespective of whether they can transfer these properties onto their outcomes. Understanding the nature and characterisation of procedures can provide some insight into how and whether procedures themselves can be considered fair and legitimate.

While Daniels & Sabin do not explicitly specify the type of procedure of AFR, Landwehr states that it is "presented as a case of pure procedural justice" (Landwehr 2013:3014) as understood in the standard Rawlsian classification of procedures. The characterisation of AFR as an instance of pure procedure is defensible since the model is a response to there being no agreement on how to ration healthcare resources, furthermore, if it is accepted that the underlying system that informs AFR is fair equality of opportunity then the case for AFR as pure proceduralism is strengthened since Rawls states that, "it is evident that the role of the principle of fair opportunity is to insure that the system of cooperation is one of pure procedural justice." (Rawls 1971:87). The notion of classifying AFR in terms of Rawls's characterisation is justified because, firstly, these characterisations are specifically concerned with fair distribution, and secondly, even though no specific reference is made in the AFR literature to the type of procedure it is, Daniels does acknowledge that the intent of an appeal to proceduralism is grounded in the Rawlsian tradition: "The retreat to procedural justice as a way of determining what is fair when we lack prior agreements on principles is a central feature of Rawls's account." (Daniels 2001:10). Rawls characterises three types of procedures: Perfect, Imperfect and Pure. In the case of the first two types, the requirement is that there is an "independent criterion for what is a fair division, a criterion defined separately from and prior to the procedure which is to be followed." (Rawls 1971:85). For perfect

procedural justice this, independently defined and specific outcome is guaranteed when applying a perfect procedure whereas for instances of imperfect procedures, "while there is an independent criterion for the correct outcome, there is no feasible procedure which is sure to lead to it." (Rawls 1971:86). Pure procedural justice, on the other hand "obtains when there is no independent criterion for the right result: instead there is a correct or fair procedure such that the outcome is likewise correct or fair, whatever it is" (Rawls 1971:86). Therefore in the absence of a defined independent criterion to establish fairness, if a pure procedure is carried out then the outcome may be considered fair: "A distinctive feature of pure procedural justice is that the procedure for determining the just result must actually be carried out; for in these cases there is no independent criterion by reference to which a definite outcome can be known to be just." (Rawls 1971:86). Landwehr's assumption of AFR as an instance of pure proceduralism may therefore be correct given that there is no independently predefined just outcome for fairly distributing healthcare.

Since it has been shown that no agreement has been reached on what the fair or correct outcomes of rationing should be, one may consider AFR to be an instance of pure proceduralism since, "In the case of pure proceduralism, no constraints are placed on the acceptability of a certain outcome except the correct application of the procedure leading to it." (Ceva 2012:186). Nevertheless, there may be a reasonable argument to not define AFR thusly. Rid makes the case for AFR to have its own, qualified categorisation which she terms 'constrained pure procedural justice' which is "an appeal to fair process to choose from an independently constrained range of options." (Rid 2009:15). She offers several reasons why AFR is not an instance of pure procedural justice: The first reason is that the Relevance Condition "indicates AFR places some substantive constraints on making limit-setting decisions." (Rid 2009:13); so even though no specific independent criteria for determining the fairness of an outcome may exist, the fairness of the outcome is *limited* to a range of criteria that are identified through the relevance condition. Secondly, she suggests that FEO may be considered the normative foundation of AFR (a more acceptable and moderate assumption than those made by Hasman & Holm) because "simply abandoning FEO…would make these previous efforts of grounding health as an object of justice worthless." (Rid 2009:13). Given this FEO background for AFR, the case for constrained pure procedural justice is further supported because it "provides a criterion of fairness that is independent of process and, as such, allows judging the outcomes of concrete processes." (Rid 2009:13). However, as previously stated, the availability of independent criteria for adjudicating the outcome of a procedure is the domain of perfect or imperfect proceduralism so Landwehr believes that AFR is a case of imperfect procedural

justice because, “through the inscription with substantial norms, the decision-making procedure becomes an instance of imperfect procedural justice: its decisions could be judged with regard to the chosen norms (for example clinical effectiveness) and challenged with regard to unwanted (not chosen) outcomes biases.” (Landwehr 2013:307). Rid rejects this imperfect categorisation because, since FEO is generally considered too indeterminate to resolve the rationing problem and provide clear guidelines for making distributional decisions, and because there are reasonable arguments that suggest that “the relevance condition is, at best as indeterminate as FEO”, this means is that, “AFR lacks the one, and only one, determinate and independent criterion of fairness that perfect and imperfect procedural justice require.” (Rid 2009:14).

If AFR is an instance of pure proceduralism (or Rid’s qualified constrained pure proceduralism) and if it can be shown to be fair, just and legitimate it does however not resolve the question of whether the outcomes that it yields are therefore also necessarily fair, just and legitimate. An important aspect of Rawls’s notions of proceduralism is the claim that in order for these procedures to yield just outcomes, they should occur “against the background of a just basic structure” and “in this kind of procedural justice the correctness of the distribution is founded on the justice of the scheme of cooperation from which it arises” (Rawls 1971:87 & 81); therefore if the procedures operate within the context of a just basic structure the issue of justice has already been “addressed at a more fundamental level” (Ceva 2010:187) so their outcomes can be considered just. However, given the existing inequalities in both health and the distribution of healthcare locally and globally, it is highly doubtful that the background within which AFR is meant to operate can be considered a just system. So, while classifying AFR in Rawlsian terms may provide better insight into the nature of the procedure, the real-world circumstances belie the possibility of the outcomes being fair if a just background is a necessary or sufficient criterion for procedural outcomes to be considered just.

Emanuela Ceva refers to the view of procedural accounts in terms of their ability to legitimise their outcomes as ‘outcome theories’ which maintain that proceduralism has normative validity based on the properties that procedures confer on their outcomes: “Procedures acquire, thus, a central role in the articulation of a concept of justice as they are thought to be capable, if correctly carried out, of transferring their properties to their outcomes.” (Ceva 2012:186). However, it still remains possible that even if a procedure can be shown to be legitimate and just, and furthermore that it operates in a just background, it is questionable whether these properties are necessarily transferred to the outcomes

they produce, meaning that the normative value of procedures remains uncertain. Ceva suggests the transference of the ethical properties of a process onto outcomes is questionable on more fundamental grounds since outcomes and procedures are separate and distinct "political and social objects" (Ceva 2012:192). So even if the background institution can be considered just there is no reason to assume institutions' procedures are relevant to the outcomes, "why," she asks, "should the criteria that apply to the qualities of one tell us something about those of the others." (Ceva 2012:192). Other than the possible practical and descriptive justifications for procedures which suggest that, "it is only if we are dealing with a situation in which there is no independent standard of fairness of a result that pure procedural justice…is enough to ensure us of the moral acceptability of the result." (Kamm 1993:304), an appeal to proceduralism in normative terms requires more support than merely its ability to confer its qualities on outcomes. Justification for proceduralism, Ceva suggests, should not be contingent on only practical necessity nor on whether the procedures' qualities are transferable: "a distinctive fruitful role for proceduralism may be preserved if we divorce the idea that the interesting point of having just procedures is their capacity of leading to just outcomes and we recognise procedures as an independent *locus* for justice in its own right." (Ceva 2012:185). Accordingly, the ethical justification for proceduralism need not be contingent on whether it can produce certain types of outcomes but, she suggests, is in itself a requirement of justice that should be viewed as "a complement to outcome theories of justice, not as an alternative to them." (Ceva 2012:185). She believes that the justice-relevant normativity of proceduralism can be abstracted from the outcomes and also that showing *legitimacy* of the procedure (which is understood as voluntary acceptance), while important, is distinct from considerations of *justice*. For Ceva the legitimacy of a procedure is concerned with the validity of *who* is granted authority and entitled to make decisions whereas the justice of a procedure resides how those decisions are reached. The conflation of legitimacy and justice in the literature, she further suggests, "bears the main responsibility for political philosophers' neglect of procedures as the proper *locus* of justice." (Ceva 2012:197). Therefore, for a procedure to be considered just it "must be morally acceptable…according to an appropriately devised test of justification capable of bringing out justice-relevant considerations and tempering the influence of morally irrelevant contingencies." (Ceva 2012:194). This understanding of a resort to procedure is particularly pertinent in the AFR framework which does not claim to provide a solution to the rationing problem, but to provide a methodology for adjudicating the problem, and if adjudication is an important element for ensuring ethical requirements can be met, then a proper process, on this complementary understanding, is an essential tool.

The debate therefore moves from transferability questions to ones concerned with the legitimacy and justice of a procedure so, for example in AFR: whether the process can support the requirements of formal justice, whether the reasons and rationales of the Relevance Condition can provide justice-relevant criteria and finally, whether decision-makers have the requisite legitimate authority. In the first case, as previously discussed, the publicity and appeals conditions are designed to support the formal requirements of justice, and for the second case, the justice relevance of the reasons, principles and rationales pivots on their ethical soundness and acceptability to all those affected by the decisions. Both these may however be contingent on the legitimate authority of the decision-makers, meaning this final requirement would be an essential criterion for determining whether AFR can be considered an ethically appropriate framework for healthcare funding decisions. If the ethical validity of the process rests on this requirement and authority in decision-making "derives legitimacy from the process through which people transfer their entitlements." (Ceva 2012:191), then certain conditions, grounded in voluntarism, may have to be met within the private healthcare funding environment for decision-making bodies to be considered legitimate authorities. Such conditions could include that: firstly, subscribers to the medical scheme must understand that they are ceding responsibility for making healthcare funding decisions to a specific organisation and are aware of the cooperative, risk-sharing nature of transaction and that their specific financial contributions will, to a greater or lesser extent, be used to fund (or cross-subsidise) healthcare for the other members in the scheme. It is not unreasonable to suggest that subscribers have sufficient awareness of these features since, as previously discussed, though members cannot be expected to understand the fine-grained minutiae of their health plans and contracts, it is reasonable to assume that they are aware that their chosen plan has certain limits and that some decision-making will be necessary. Furthermore, while the cross-subsidising nature of these schemes is less openly acknowledged by subscribers and no one chooses to join a medical scheme for altruistic reasons, only the deliberately obtuse would believe their contributions do not supplement the healthcare funding needs of others in the cooperative scheme. Secondly, legitimate authority would be dependent on the nature of the decision-makers who should be more than merely fair-minded, there should be proper governance (as suggested by the Regulatory Condition) of the decision-making body and they should have an adequate understanding of the industry.

A final possible way to solidify the legitimacy of a process may be to establish whether it adequately provides a platform for fair deliberation whereby all positions and options can receive a fair h earing to ensure that the, "requirement that all sides in a conflict be heard can be read as the expression of a

commitment to making sure that the authority to decide of a conflictual issue is distributed evenly between all relevant parties, so that no one can prevail unduly over others." (Ceva 2012:188). Since, as previously discussed, deliberation seems to be an integral component of AFR, it is reasonable to claim that it meets the criteria of fair deliberation if properly applied. So, while a procedure such as AFR may not necessarily confer its ethical properties on the outcomes, it may be reasonable to claim that it is sufficiently robust to be considered a just and legitimate procedure even if not everyone necessarily agrees that it is the correct procedure for guiding rationing decisions.

A specific objection to AFR in terms of proceduralism is that "it is not clear that the concern for justice underlying the problem of rationing health care services will be addressed by such a procedural account alone." (Sabik & Lie 2008:82). However, it should again be noted that Daniels & Sabin have not proposed AFR as a solution to the rationing debate, but is presented as a process to achieve legitimacy and fairness for decisions. Still, if the objections to AFR are considered sufficient to eliminate it as a valid ethical methodology, if Ceva is correct then the need for a fair and legitimate process may still be a necessary requirement of justice and that when evaluating justice of an institution, "one should not only look at how the costs and benefits of cooperation are distributed but *how* the cooperation is itself articulated, whether its constitutive procedures treat the co-operators in ways they find morally acceptable." (Ceva 2012:197, own emphasis). In this way an appeal to procedures cannot merely be considered as attempts to find practical ways to address the unresolved ethical problems based on their outcomes, but necessary requirements of justice, as Ceva concludes: "Proceduralism can say something relevant about justice if conceived in these terms, provided that criteria qualifying just procedures are kept separate from those which qualify just outcomes." (Ceva 2012:198). Even so, AFR may be distinguished as a unique procedural account since, if the reasons specified in the Relevance Condition appropriately consider all the ethical obligations of the institution, it may be seen to incorporate substantive principles into its structure which would be compatible with the view that while procedural justice "should continue to play a central role in making limit-setting decisions about health care. Discussion of substantive principles that underlie decisions should be of equal concern." (Sabik & Lie 2008:84).

CONCLUSION

Even if the AFR framework can be shown to be just and legitimate and the Relevance Condition to successfully incorporate substantive ethical criteria, a straightforward application of AFR as a proposed

solution for guaranteeing ethical micro-level funding decisions is questionable since the mere appeal to a procedural account cannot guarantee just outcomes or resolve the moral complexities surrounding these decisions. This is particularly true since the existing background conditions of the healthcare industry cannot be considered just, and while it is possible to suggest that the private healthcare industry, based on fair market exchanges, may provide this necessary background condition, the compromised consensual nature of these exchanges weaken this claim. Nevertheless, if Ceva is correct, having an acceptable and legitimate process within which difficult ethical decisions are properly deliberated is itself a requirement of justice and the Publicity, Revision and Appeals, and Regulative conditions may meet this requirement, if only to provide a platform for consistent, impartial and transparent ethical deliberation which are critical elements to ensure fairness. As appealing as it would be to find as tool through which to filter and resolve ethical predicaments, simple solutions will not do justice to the moral complexities surrounding healthcare decision-making and while healthcare rationing may remain unresolved, none of the ethical principles that govern the debate may be dismissed. If we are to respect the dignity of all human beings and not treat them as mere means to ends, then we owe it to them to carefully deliberate each exceptional case based on these ethical principles and the discrete relevant moral factors, and to be cognisant of the relative social importance and responsibility attached to healthcare; if all AFR can achieve is to provide such a deliberative platform, with the Relevance Condition merely the locus for principled deliberation, then it can, at the very least, improve the rigour of making ethical decisions.

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