Judging goodness must come before judging quality – but what is the good of health care?

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Abstract

The paper argues first that until it is known what the good of health care is there cannot be a judgement about what is better, and second that until it is known what is better there cannot be a judgement about what is quality. It is further suggested that in judging good and better with respect to health care as a social institution, there is no-one better placed to do this than the community. Too little is currently known about what communities want from their health services. Some suggestions as to how this situation might be improved in both principle and practice are discussed and the notion of ‘communitarian claims’ linked to conjoint analysis posited as a useful way forward. Such an approach will allow the development of a set of community-based principles – what is called a ‘communitarian constitution’ – on which to base the direction and objectives of health care.

Keywords: communitarian claims, community preferences, efficiency, equity, nature of the good, quality

Dealing with quality in health services is difficult not least because of the problems of definition. What is quality? The basic point of this paper is simple. It is argued that there is a need to be clearer than is often currently the case about the nature of the good that quality is designed to serve. Quality or higher quality must relate in some way to the concept of better. It would then seem to follow that there is a need to be clear and reach some sort of agreement among the relevant stakeholders about the nature of the good before it becomes possible to define what is meant by ‘better’ and in turn the nature of quality.

There is a second point that this paper seeks to make. It might seem at best inappropriate to claim that the good of health services is about more than health. While this is recognized in some policy documents [1,2], it is often only lip service that is paid to pursuing the other attributes. For example evidence-based medicine is dominated by concerns for health, as is much of the economics literature especially that on Quality Adjusted Life Years (QALYs) and QALY league tables [3].

Quality and the nature of the good

In the discipline of economics (the author’s discipline), quality or, more accurately, higher quality is something for which consumers are prepared to pay more. That is relatively straightforward with respect to most commodities in the market such as cars and wine. Health care, however, is much more problematic in this sense of quality. Judging quality requires relatively good information. When consuming health care, patients often do not know what is wrong with them, what treatments are available or what the effectiveness of care might be. Often they cannot judge quality of treatment before the event and often cannot afterwards either. In such ignorance, as consumers we cannot leave health care to the market. The question then arises as to who is to judge quality and who is to judge the ‘good’ that can be achieved through health care.

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In most practical policy circumstances, if an intervention produces more or greater health gains, then, other things being equal it is likely to be judged to be of higher quality. This does not always follow, however, and there will be instances where attempting to produce more health (for
example in the terminally ill) could reduce the quality of care [4]. However, the situation is changing for the better: in palliative care for example there is increasing recognition of the multiplicity of outcomes and processes [5]; considerations such as respect for the dignity of the patient, caring and being cared for, the feelings of the patients' relatives (and after death the bereaved) may all be relevant. For many other circumstances and conditions, at least some of these factors may well come into play together with additional, even if intangible, ones – consideration, respect for autonomy, reassurance, etc. There is a need to make it much clearer which of these are relevant at what time and the relative weights to be attached to them. There is often a need to act upon these wider sets of factors not only in policy but also in clinical trials.

What emerges from any attempt to list all of the relevant characteristics are three things. First nature of the good in health care is potentially multi-faceted; second it is not enough to recognize and list all of the factors, there is also a need to determine their relative weights; and third there is a case for more discussion about what the good is. There is some research that can inform the debate [6–8]. More is needed with respect to both individual interventions and health care systems at a more macro level.

Even with chocolates, cars and wine, in the liberal democratic market place, there are problems. This is because in liberal democracy, the nature of the good is not defined. Liberalism argues simply that individuals should have the right and the ability to express their own preferences. This is certainly the basis of market economics. The 'good' there is judged by the aggregation of individual preferences. Only individual preferences count. This monopoly of individual preferences leaves no place for a social construct or community concept of the good. Indeed it may be argued that the dominance of individual preferences is potentially dangerous, as some preferences are good but others not so, such as, for example, those which are racist.

## Quality and equity

Health services are also frequently about equity. Yet the extent to which this is taken into account in judgements about quality is limited.

For example can Australia claim to have a 'quality' health care system when considerations of equity are brought into consideration? Australia is among the world leaders in terms of the proportion of health care spending that is private. Since ability to pay as a basis for accessing health care is normally seen as inequitable and private health insurance is more accessible to the rich than to the poor, this is inequitable. Second there is the appalling state of health of indigenous Australians. Certainly the USA, Canada and New Zealand suffer from similar problems [9] but the gap between indigenous and non-indigenous health in Australia is much wider than in these others. Can Australia claim to have a quality health care system when we are failing the worst off in the community?

Certainly Australia does spend more per capita on indigenous than on non-indigenous health care, 8 cents more in the dollar [10]. That 8 cents would not begin to compensate for the access costs that many Aboriginal people face in living in the more remote areas of Australia. Further and more importantly, there is a need to set that 8 cents against the fact that life expectancy among Aboriginal people is almost 20 years shorter than that of non-indigenous Australians [11].

In Australia inequities in health care gather pace. Most recently the Federal (national) government decided to provide a 30% rebate to every one with private health insurance at a cost to the taxpayers of $1.7 billion. That money could have tripled the spending on Aboriginal health services. Instead it went into the pockets of the well off.

With respect to vertical equity [12] the question arises as to the good of health care however it is defined. Do the benefits to the disadvantaged get weighted more highly in a form of 'positive discrimination'?

With Stephen Jan [12] I argued that for the purposes of such equity there may well be reasons why health gains and other benefits from health care (say to Aborigines) might be weighted socially more highly than for non-Aborigines. In a study of the South Australian community this is what we found [8,13]. Thus any 'good' that appears to be nominally equal may not be constant and independent of the recipients.

What is the good of health care? To answer this question we need to research this more than has been the case to date.

## Health care good and wider issues

What's the good of health care? That question can be interpreted with a cynical edge to it. Even when a health service is doing good, there is a need to look to a wider environment if the concern is with health or the good more generally.

From Australia two examples serve to illustrate this point of the problems for health at a wider level. Australia is currently facing tax reforms on two fronts. The introduction of a sales tax is regressive. Further a recent government report advocates reductions in capital gains tax and in business taxation. These changes in particular are strongly regressive. It is known that poverty and ill-health are linked. These new tax regimes will increase poverty and ill-health. Secondly the legislation on land for Australian indigenous people, for whom there are such close links between land, self-esteem and health, has been deemed racist by the United Nations.

Against that background and the impact of these measures, and others, on the welfare and income of the most vulnerable sections of the Australian community, and the very clear links between such vulnerability and ill-health, it becomes appropriate to use the title of this paper in another way. Faced with these government policies which have such adverse effects on the health of the population, then it becomes possible to ask rhetorically: What's the good of health services?

These issues have international resonance. Looking more explicitly internationally, however, it is relevant to consider
an initiative from WHO and the World Bank. In recent years, these two global organizations have called for various countries to calculate the burden of disease [14]. Such estimates are to be used to help priority setting and to allow comparisons, for example, between countries in the extent of the burden from different diseases, e.g. in India compared with Ireland. It is important to question this (not least because so many countries – especially the developing ones – are investing heavily in these analyses and one worries about the opportunity cost involved given the scarcity of analytical skills in many of these countries). Questions are needed here although in this paper I will restrict myself to issues related to the nature of the good. (For a wider critique see [15].) First it is not immediately obvious why the Indians and the Irish would be interested in such comparisons. Second it is not necessarily the case that a nominally equal health loss or health gain in India will be valued the same as its counterpart in Ireland or Italy. Third it is questionable whether, as is assumed in these calculations, the only thing that health services are about is health.

This is global elitism. It is the judgements of WHO and the World Bank which drive these assumptions and not those of the societies where their policies are to be pursued. They assume that they know the nature of our good from health services and that it is constant across all cultures. There is a need to ask the Indians and the Irish and the Italians what they want from their health services. What is the nature of the ‘good’ that these different societies and different cultures want from their health services?

Even if the objectives of health care were constrained to health, the construct of health can vary across cultures, even sometimes within the one culture. There is a need to embrace social values and set up research to establish such social values. At the same time it is necessary to reject the reductionism of epidemiology, especially the reductionist value base of epidemiology which seeks a monopoly position for health.

**Communitarian claims**

The way forward is to elicit the values, the principles on which each society or community wants to build its health services. In this context it is important to see health services as belonging to citizens as a community. Once health care systems are identified as social institutions which belong to the community, it then becomes possible to appraise, on the basis of these principles (or what I have referred to elsewhere as ‘a constitution’ [16]) the objectives that society or the community want for their health services. We can thereby obtain the divining of the good.

It is argued that there are advantages in adopting a more communitarian position in health care, especially at a systems-wide level. Such a position, even if not in the specific context of health care, is defined by Cullen [17] as arguing ‘that we cannot justify political arrangements without reference to common purposes and ends, and that we can neither conceive our personhood nor know the good without reference to our role as citizens and as participants in a common life’. Values are not just individual values but born of membership of a community or communities. Thus, as Avineri and de Shalit [18] state: ‘in order to justify the special obligations that we hold to members of our communities – families, nations, and so forth – one must attach some intrinsic (i.e. non-instrumental) value to the community itself and to our relations with other members of the community’.

Walzer [19] states: ‘Membership [of a democratic society] is important because of what the members of a political community owe to one another and to no one else, or to no one else in the same degree. And the first thing they owe is the communal provision of security and welfare’. I would add ‘i.e. the community recognizes that different people have different claims on the community’s resources’.

This notion of claims is potentially rather important. In defining what he means by it Broome [20] states: ‘To take account of fairness we must start by dividing the reasons why a person should get a good into two classes: ‘claims’ and other reasons. By a claim to the good I mean a duty owed to the candidate herself that she should have it’. He continues: ‘Claims... are the object of fairness’.

Broome’s concept of claims seems (following Walzer) again dependent on there being a society within which there is arbitration over claims. Such claims are not absolute. The community has to decide the strengths of different claims as not all claims will be equal nor will all claims be able to be met with the resources available.

One constraint on all of this, as Sen [21] indicates, is that ‘If social conditioning makes a person lack the courage to choose (perhaps even to ‘desire’ what is denied but what would be valued if chosen) then it would be unfair to undertake the ethical assessment assuming that she does have that effective choice’. He continues: ‘an overdependence on what people ‘manage to desire’ is one of the limiting aspects of utilitarian ethics, which is particularly neglectful of the claims of those who are too subdued or broken to have the courage to desire too much’.

A ‘claim’ in neo-classical market economics would presumably be related to the marginal productivity or output of labour or indeed of any other factor of production. Claims under that paradigm and indeed strengths of claims are a function of what one contributes to society by way of economic production. In their criticisms of expected utility theory, it can readily be argued that it is this aspect that has united, *inter alia*, Marxists (on grounds of the illegitimacy of claims based on capital accumulation and hence exploitation of the claims of workers who then do not have the strengths of their claims recognized adequately) and feminists (who argue *inter alia* that women’s contributions to the economy and to society more generally are not reflected adequately in the narrow concerns of the marginal productivity of labour and hence – and here is the attraction of the ‘claims paradigm’ – women’s claims and especially the strengths of their claims in a world of neo-classical economics are not weighted highly enough).

Fortunately what might be a serious block to progress under a utilitarian paradigm ceases to be if we adopt the concept of claims. One key element of a claim, as Broome
explains, is that an unfair distribution is such ‘because someone’s claim has not been satisfied in proportion to its strength’. He adds that: ‘Unfairness is a harm that is done [to a person], but not all harms are necessarily bad feelings’. So a person can be ‘harmed’, unfairness or inequity can as a result exist but without that harmed person necessarily feeling bad about it. Thus if the Sen-ite person does not feel badly or not seemingly adequately badly because he or she has been harmed, that does not alter the fact that the harm exists and that, hence, inequity exists. The strength of a claim is not a function of the individual’s ability to manage to feel harmed (which is presumably close to the converse of managing to desire). The strength of a claim is determined by the duty owed by society to the individual harmed, where the harm and the extent (and strength) of the harm is determined by the society rather than by the bad feelings arising for the person harmed.

Broome’s analysis concentrates on claims as a basis for fairness. I have suggested previously [22] that the notion can be extended to include concerns for both efficiency and fairness and that the concept of ‘communitarian claims’ may be helpful in deciding how best to allocate society’s scarce resources in the specific context of health care. Such communitarian claims ‘recognize first that the duty is owed by the community of which the candidate is a member and secondly that the carrying out of this duty is not just instrumental but is good in itself’ [23].

**A communitarian constitution**

Using communitarian claims accepts that more democracy is ‘a good thing’ but not that that has to be with respect to valuing all social goods. Rather these claims can be used to allow a democratic setting of the principles of health care which can then be used as a guide for the policy makers to pursue quality initiatives. It is to this set of ‘principles’ that, together with my colleague Virginia Wiseman [16], I have referred elsewhere as a ‘constitution for health services’. This is simply an attempt to get the community to define what they want from their health services. This can then be used to inform, without necessarily dictating, health care policy choices.

This question of sorting out the nature of the good on which to build is present in all aspects of health services. The actual content may vary from one set of services to another. This was demonstrated by my colleague Stephen Jan [24]. In evaluating a screening program for otitis media in Aboriginal infants, he states that, in addition to the impact on the hearing of children, ‘two other potential outcomes were the training and employment given to the Aboriginal Health Worker and the window of access into the health care system provided to the mothers and families affected by the service’.

It would be possible to continue to rely on some more liberal based conception of the good, essentially some aggregation of individual preferences. There is no intention to rule that out as a possible option for defining the good of health care. Yet it seems inadequate.

With respect to health care as a system, there is a strong case for considering this social institution in terms of shared responsibilities. There are greater concerns for others’ health and access to health care than with respect to most other characteristics of human beings. To adopt the values of individualism, whether individual responsibilities or individual rights, seems to lead almost inexorably to market solutions in health care. There is clear empirical evidence that in at least the great majority of OECD countries the market solution has been rejected in large part or in some cases almost completely.

Baier [25] argues strongly (even if not in the specific context of health care) for an acceptance of greater shared responsibilities. She states: ‘If we insist on clinging to the idea that moral responsibility must divide without remainder in to the bit that is mine and not yours, and the other bits that belong exclusively to specific individuals, then not only will we limit the sort of shared actions we engage in but we will drastically limit our ability to reform our inherited schemes of co-operation for the better’.

It is significant that health care is dealing with a situation where individuals’ autonomy is threatened. Anyone who is sick, especially if seriously ill, is at risk of having her or his individual autonomy undermined. Individuals when sick are weak [26] are less likely to act rationally and in an informed way [27]. It then behoves us as a society to try to ensure that the nature of the good that health care provides encompasses what it can to ameliorate or even compensate for this loss of individual autonomy. It is at times when we are ill that we need an assurance that there is a goodness in health care that accepts the need for support for our at-risk individual autonomy and our capacity at such times to be able to act autonomously. It follows that the autonomy that underlies the good of health care must be more than and different from the individual autonomy that liberalism supports. It is the case, as Gibson [28] suggests in another context, that autonomy ‘is not a fundamentally individualistic idea that must somehow be accommodated to the undeniable interdependency of individuals with one another and their environment. Rather, autonomy is, in its origins and at its very core, a social phenomenon resulting from relations of co-operation and attitudes of mutual respect among persons who regard themselves and each other as equals’.

Hiskes [29] comments on Gould’s ‘ontology of individuals-in-relations’ [30], suggesting that ‘as social beings, individuals require relations of reciprocity as one of the social conditions of their self-development’. He argues: ‘This reciprocity is necessary for both the physical and psychological resources that individuals need for achievement of their purposes’.

Hiskes’ observations are made in the context of individuals’ and society’s attitudes to risk. He suggests [29] that ‘almost nothing calls attention to the interconnectedness of individual lives as much as do modern technological risks. Almost nothing seems to challenge our autonomy more, in the face of modern risks we feel anything but free as individuals to autonomously determine the future course of our lives’.
Almost nothing; but perhaps ill-health does, with the resultant need for society to respond as a society or community.

All of this would seem to suggest that the liberal market conception of the good is at best inadequate in health care. We need some more community focus or communitarian value base. This is in essence what Habermas [31] seems to be referring to in his critique of modern democratic institutions when he writes of the need for citizens or the community to ‘lay siege’ to the bureaucracy. The intent is not to build a new democracy but to allow the community to determine the constitution for health services i.e. that set of rules for collective decision making which are to determine the nature of the good and in turn inform the objectives and the policies of the health care system.

Precisely in which circumstances the community’s preferences might be used to inform policy is an important issue (raised by one of the reviewers). One way to handle this is to argue that the community should have a chance to say when they want their preferences to count. (This the subject of a study being undertaken currently by Virginia Wiseman, one of my colleagues.)

Conclusion

Quality cannot be defined without some clear and agreed conception of the good. Deciding how to move forward on this is in principle easy. There is a need to identify better than is currently the case what is meant by the social good of health services and to do that before going further into the debate on quality in health care. There is a need to recognize anew that health services are a social organization and that health services are there to serve the population. It is the values of the community that should drive health services. The concerns for equity are social concerns. Doctors are servants of the people. There is a need for a ‘constitution’ for health services. There has been an ongoing debate in the health care literature over what role the general public should play in health care planning. Sceptics of public involvement have expressed concerns over the limited interests and expertise of the public. Advocates have argued that, regardless of the problems involved, it is ultimately society’s resources that are being allocated and therefore society’s preferences that should count.

To get the citizenry heavily involved in valuation issues at the level of detailed priority setting is not practical. They do not have the time and the ‘information overload’ that would result in making such a proposition unworkable anyway. The cost to them would be just too great. The cost of relying on the individualism of the market is also too high. Setting up a constitution, informed by community values, represents a useful middle ground.

In Australia (with some of my colleagues), we have begun to experiment with some of these ideas. In one study we worked with staff of the South Australian Health Commission to try to elicit the principles on which policy makers were operating. The aim of this exercise was to begin to develop a strategy or framework for purchasing. Thereafter we extended the approach to the South Australian community to get their preferences for the ‘constitution’ for health services using the technique of conjoint analysis [8,13]. We have since used this approach in other health services and are in discussion with South African colleagues to attempt something similar there.

This is exciting and positive. Resolving some of the riddles surrounding issues of quality requires that the nature of the good is defined better and more explicitly than as of now. Only then can the best way forward be determined with respect to quality.

The idea of stepping back and thinking through the principles on which societies seek to build their health services is a simple one. It is also largely a neglected one. Questions of the appropriateness of market forces in health care, of evidence bases, of health outcomes measurement and of quality cannot satisfactorily nor comprehensively be addressed until there is clarity of the values that should drive the health care system. There is a need to identify, through the community, what the good is that citizens want from health care services. Scientific status, quantification and the technical wizardry of high tech medicine are all legitimate drivers of health care policy. They do not nor can they be asked to tell societies nor health services how to proceed. Nor can they provide the values to give such answers. That set of values – that ‘constitution for health services’ – has to come from elsewhere, best from the community whose health services these are. It is that constitution which can then provide in turn the foundation for informing better what is to be meant by quality in health care.

Acknowledgements

An earlier version of this paper was presented at the ISQUA Conference in Melbourne in 1999. I am grateful for comments received at that time. I also thank Glenn Salkeld, Stephen Jan and Virginia Wiseman in the Social and Public Health Economics Research Group (SPHERe) and two anonymous referees for their most helpful comments.

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Accepted for publication 12 July 2000