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Guest editorial

Need - is a consensus possible?

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Medical care is commonly cited as a service to be distributed according to "need".[1] There are those, (such as Barry and Flew,[2] who interpret "need" instrumentally, that is, that the thing or state asserted to be needed is necessary to achieve some more ultimate purpose. This view is opposed by others, such as Miller and Thomson,[3] on the ground that statements using the word "need" are intrinsic or elliptical, implying an objective that would be trivial to make explicit (the statement "I need open heart surgery" is not much elucidated by adding "if I am to live"). In medicine (and elsewhere too, no doubt) the intrinsic concept is hardly tenable: the great value of the instrumental view is that it confronts practice with the necessity to be explicit about whether it is effective, how effective it is and for whom. Since much practice has in the past been demonstrably ineffective (if not plain harmful) emphasising the role of medicine as a means rather than an end in itself is a non-trivial matter and, on the face of it, the instrumental approach seems to be a useful point of departure.

It may be an illusion to suppose that there might ever be a consensus about the meaning of "need", even if the context of its use were specific (thus permitting other concepts in other contexts) and even if it were merely provisional (contingent on a manifest improvement for the context in question or a generalisation that embraced this and other contexts). The attempt seems, however, worthwhile.

The context I propose is a planning context in which broad decisions have to be taken about the allocation of resources, for example (British) to the National Health Service (NHS) out of the health vote, or to regions in the NHS, to health authorities in regions, or to trusts and general practitioners by health authorities through commissioning, to decisions about priority groups of beneficiaries, or as between preventive and other types of health care. Common features in all these decisions are that they relate to aggregates of people rather than specific individuals with their own preferences, fears and personal circumstances, all of which normally require attention in individual decisions (preferably joint, for example, by doctor and patient).

I suggest that the concept of "need" in these situations ought to have two elements. The first is empirical: given a goal defined in terms of outcome, there should be empirical evidence (preferably valid and reliable) that the thing or state said to be needed can (with acceptable probability) actually achieve the goal set. The second is ethical: the goal set and the means adopted to realise it ought to be ethically compelling. It is this latter requirement that gives "need" its ethically compelling quality, while the former requirement is essentially a cost-effectiveness condition embodying technological knowledge about the effects on outcomes that procedures may be expected to have and opportunity costs, so that the means chosen to realise the goal maximise the residual availability of resources to meet similar needs of other groups and individuals for similar morally compelling goals.

Thus, one might assert that "health" is needed if people are to "flourish", that there is indeed evidence to support the proposition that "health" will actually enable the group in question to "flourish" better, and "flourishing" is indeed the ultimate ethical good which transmits its moral persuasiveness to "health", making that too a good thing (an instrumental good thing). In such a case, ill health indicates a need (for health). This may come close to what some have taken as the intrinsic view. Or, one might argue that health care is needed if people are to have better "health", that the specific health care proposed is likely to produce the appropriate "health" gain sought, and that the ultimate good of "flourishing" now transmits its moral persuasiveness to health care, which is therefore an instrumental good thing for the achievement of better "health". In this case, ill health does not *necessarily* indicate a need for health care, evidence of its cost-effectiveness being required to reach this conclusion. This contrasts with Daniels[4] for whom the need for care depends not on the ability of care to return a person's impairment to the "normal opportunity range" but on the magnitude of the existing shortfall from

that range, which I would interpret as a need for "health", not health care.

I assert that the need for health care is the amount (and type) of health care that is necessary to eliminate a person's capacity to benefit from it in terms of "health" gain.[5] This is not the same as *identifying* need with capacity to benefit. Embodied in this is the idea that only cost-effective care is relevant (so, for example, a more costly procedure having the same probable outcome for "health" cannot be necessary to achieve the objective and therefore neither is it needed since there is a cheaper alternative whose use will incidentally but importantly leave more resources over to meet other needs). This definition of the need for health care does not imply either that each need should be completely met nor that all individuals' needs should even be partially met. Some unmet need (for example, an additional day in hospital) may add so little additional benefit that other higher marginal needs trump it while other needs may be so minor in their totality that one may not even begin to provide health care in such cases, and for the same reason. (More on categorical absolutes later.)

Analytical benefits

This approach has a number of benefits. Some are analytical. One is that we can draw a meaningful distinction between the need for "health" and need for health care (for example, an individual may unambiguously need "health" but not need health care, perhaps because the care that is or might feasibly be available will not affect "health" for the better). Another analytical advantage is that one may substitute both other ultimate objectives (than "flourishing") and proximate means (than health care). One might, for example, think "flourishing" an inadequate ultimate objective for hospices and want to substitute something more appropriate from which would cascade a derived need for hospice care. Or the need for better housing or parenting or social care (rather than health care) might be justified via a "flourishing"→"health" route (as well as others). Yet another is that the concept can be used explicitly in criteria for distributive justice in health care. For example, is distribution of health and social care a proper ultimate objective of distributive justice, with the resultant "health" distribution being whatever it is, or should a desired distribution of population "health" be the driver that determines the distribution of resources? Practical advantages include the incorporation of the drive for evidence-based professional activity into a clear ethical framework, and the provision of a clear set of principles to inform scoping exercises, research priorities, data collection to support future allocation decisions, and so on.

Consensus

My central point here is that the twin structure of the concept is what we may be able to achieve a consensus upon, even if we disagree about the virtue of specific ultimate objectives or the evidence about the cost-effectiveness of alternative means of realising any particular objective. Additional ethical questions arise concerning these details, like who ought (morally speaking) to determine ultimate - or even proximate - objectives and who ought (morally speaking) to adjudicate about the efficacy and cost-effectiveness of procedures, whether clinical, managerial or political. My structure does not make presumptions about the answers to any of these questions.

The proposed structure makes no assumptions about the character of the ultimate or proximate objectives (like "flourishing" or "health"). Of course, decisions are required about what we mean by these things and, if it is necessary for them to be measured, what the measure should be, what the required degree of validity is, and so on. But disagreements about these details, important though both the disagreements and the details themselves are, can be managed within the structure and the structure does not dictate specific solutions.

No absolute or categorical sense of need is implicit in the structure proposed. "Need" is not an overriding reason for doing anything. Its persuasiveness depends upon the persuasiveness of the moral objective in question, the cost-effectiveness of the means proposed for achieving it and the resolution of any conflict between needs asserted for one thing on one ground as against the needs asserted for other things on other grounds. It is commonly asserted that "we" need both health care and defence. Both may even have their ultimate moral justification in terms of "flourishing". However, the one set of needs does not obviously trump the others. In both cases it is likely that some needs (one hopes the less pressing ones) are likely to remain unmet because of resource constraints. Need is both relative and graduated since "health" is also relative and graduated - and so is health care. "Health" is variable, for example, in terms of functioning, activities of daily living, experience of pain, mobility, longevity - and it is also at least in part culturally determined. An extreme example of a clinical disease not regarded as "being ill" is pinto (dichromatic spirochetosis), a skin disease so prevalent amongst some South American tribes that the few

single men not afflicted were regarded as pathological to the point of being excluded from marriage.

Another absolutism is offered by Harris[6] who argues that life-saving has priority over life-enhancement, so the smallest possibility of the shortest extension to the most miserable of lives is to receive priority over the most sure and massive improvement in the quality of a life already expected to be long. This seems a cruel implication of absolutism: a moral commitment held irrespective of its consequences and the harm they might inflict.

Interesting sideline

An interesting sideline arises when one considers what is being taken for granted, organisationally, economically or technologically. For some purposes one might want to take existing structures, budgets and technologies as given (for example, in deciding where cancer services need to be located); for others one might want to address budgets or structure explicitly and ask what a needs-led "system" requires of these; for others one might want to engage in horizon scanning in order to anticipate coming technologies and better plan their needed diffusion; for yet others one might want actively to encourage certain lines of research in order that they might develop technologies to address needs for "health" that current technologies are ineffective for and for which there is therefore currently no need. It thus becomes possible to talk in the same way about the need for research and development as for the need for health care.

Though instrumental in character the structure does not imply that procedures (like medical care) or states (like being "healthy") are always merely instrumental for more ultimate purposes. While it is (practically speaking) a good discipline for (say) general practitioners (GPs) to reflect on the evidence base for their judgments about how to meet the needs of patients (collectively or individually), medical care does not have the sole purpose of making people's "health" better than it otherwise would have been. General practitioners also provide information, reassurance, other kinds of advice and opinions for other kinds of purpose (such as insurance claims). These may promote "flourishing" (or something else that is highly morally compelling) but they are hardly medical care and may not even involve medical judgments. So, while the health care system's main job (the secretary of state asserts) is the promotion of "health", there are other functions too, which may be needed. Whether they are needed or not can be considered within the structure I propose. Moreover, even procedures and organisational structures that are primarily intended to be instrumental means towards some more ultimate moral goal are commonly required also to show other (moral) characteristics. For example, cheap access (not the same, of course, as equal access) to a GP gatekeeper may be needed (in my sense) if the twin goals of better "health" and a better distribution of it are to be realised. But cheap access may also be morally justified on other, for example communitarian, grounds. Or a GP may decide that some types of patient need (in my sense) a procedure that is known to be generally (cost-) ineffective relative to placebo but which she may have rational and evidential grounds for supposing would actually yield a more substantial placebo effect for the specific types of people in question. If such a procedure were thought to be the more cost-effective treatment plan, then it is needed. Of course, in such cases (at least if they were common in a particular practice) the pattern of care might become an object of scrutiny of health authorities, who ought likewise to bear in mind that evidence-based medicine is intended as an aid to thought rather than a substitute for it. Moreover we commonly require organisational processes to meet certain tests, such as openness or confidentiality (depending on the circumstances), which may also be said to be needed (in my sense) or which might derive their moral justification in other ways. Thus, while there are some issues which are usefully considered in terms of "need", others might be better considered in the realm of rights and entitlements (for example, a right to be consulted about a medical procedure before a decision is taken). There is no especial reason why an instrumental view of need should not sit within a pluralistic view of medical ethics.[7]

Implications

The following implications (of many) flow more or less directly from this kind of analysis:

(a)need for health care and ill "health" are not synonyms;

(b)capacity to benefit from health care is not a synonym for the need for it;

(c)need is prospective rather than retrospective (it draws attention to what can be done for people rather than what has previously happened to them or what their present state is; past and present are relevant only inasmuch as they may affect what can be done or suggest lessons for avoiding future ill "health");

(d)it will usually be equitable for some needs to go unmet (if resources are insufficient to meet all needs);

(e)it will usually be efficient for some needs to go unmet (if resources are insufficient to meet all needs);

(f)if equity requires that services go only to those who need them, then access to the health care system needs to be cheap rather than equal (in order that needs may be assessed), so cheap access is instrumental too!

(g)although it is instrumental, the usage proposed for "need" is not exclusive of other ethical systems.

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References

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News and notes

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