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Health Care Rationing and Distributive Justice*

Abstract:

The rapid progress in medical technology makes it unavoidable to ration health care. In the discussion how to ration many people claim that principles of justice in distributing scarce resources should be applied. In this paper we argue that medical resources are not scarce as such but scarcity is a necessary by-product of collective financing arrangements such as social health insurance. So the right question to ask is the determination of the benefit package of such an institution. Hartmut Kliemt is currently involved in a commendable interdisciplinary research project in which principles of ‘prioritization’ of medical care are studied. This contribution adds a specific perspective to this endeavour: we ask how the goal of distributive justice can be interpreted in this context and compare different approaches to implementing ‘just’ allocation mechanisms.

1. Introduction

The problem of distributive justice is primarily relevant for goods that are scarce in an absolute sense such as pieces of land at the shore of Lake Constance or tickets to the Vienna Opera Ball. For goods that can be produced and whose quantity can thereby be augmented the access can in principle be left to the market. These are then allocated according to the *willingness-to-pay*, which has the advantage that the demand side sends signals to producers to increase production in case of need and thereby to remove any scarcity. The allocation of these goods does not create an issue of distributive justice, except in the very general sense that citizens can differ in their *ability-to-pay*, which is related to their ability to earn income. But this is a problem that is related not only to health care services but to all goods that meet basic needs and that can be solved within the system of taxes and transfers, for example by guaranteeing a minimum income at or above the subsistence level.

What is special about health care? It is the fact that with these goods the *need*—e.g. measured by the risk of illness—can differ tremendously among citizens, in part, even if not exclusively, for reasons beyond the individuals control, especially due to his genetic endowment. As a consequence, in an unregulated

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market for private health insurance contracts the so-called 'high risks' must pay higher premiums for the same insurance coverage than 'low risks'. This fact is seen by many as an injustice by nature which can be—at least with respect to its financial consequences—corrected by government. By establishing a mandatory insurance with open enrolment and community rating (more precisely, the prohibition of risk-related premiums) it can ensure that low risks bear an equal share of the financial burden of high risks. The above mentioned properties of mandatory membership, open enrolment and community rating are characteristics of 'social' health insurance.¹

Once the basic decision has been taken to establish a social health insurance, it has to be decided what shall be its benefit package and the rules that govern its functioning, in particular how it is financed. These questions can be addressed with respect to criteria of distributive justice, but other normative principles such as efficiency, freedom and conformity with the rule of law are applicable as well.

In this contribution we shall try to survey the health economics literature with respect to the question what normative requirements must be met in the determination of the benefit package of a social health insurance in a democratic state committed to the rule of law. To this end, we shall first argue (in *Section 2*) why the answer can not be the trivial one that all 'medically necessary' services must be included in this benefit package. In *Section 3* we shall discuss the set of 'other' normative requirements in greater detail and apply it to the determination of the benefit package before we turn to the central question of distributive justice in *Section 4*. *Section 5* is devoted to a special problem, viz. the just allocation of absolutely scarce commodities in health care, which we shall answer using the example of allocating human organs for transplantation, and *Section 6* concludes.

At this point, the reader might miss a question that is frequently addressed in the context of distributive justice in health care, namely how health care providers shall allocate the scarce resources in their command (operating rooms, time of physicians and nurses, medical supplies) in a just way, when more patients need medical treatment than can be treated at the same time. This question of 'rationing at the bedside' or (expressed more nobly) 'microallocation at the lower level' (Engelhardt 1986, 346; Dietrich et al. 2003; Rosenmayer 2007), which is relevant especially in triage situations, is in my view of lesser importance, if not altogether avoidable once the primary problem of determining the benefit package of social health insurance has been solved in a consistent manner. I shall return to this assertion in *Section 3.2*.

¹ See, e.g. Breyer and Zweifel 2006. Some economists claim that the same objective can also be reached with other instruments, in particular a combination of private insurance and a compensation in the tax-transfer system. On this see Oberender et al. 2006; Zweifel and Breuer 2006; Kifmann and Roeder 2008.

2. On the Finiteness of Resources in the Health Care Sector

Consider a society in which health services are financed through mandatory contributions and supplied to the patient at zero or negligible cost. If we further assume that the political system is democratic, then it follows that society must somehow decide on the rules which should govern the provision of collectively financed services to the consumers and the financing of the ensuing costs.

The most extreme option would run as follows: Based on a clear-cut definition of the term 'health service' all citizens have a claim to receive all health services that they demand or, respectively, that are prescribed by an acknowledged physician. Corresponding to popular language, this option would be called 'absence of rationing'.² If, however, rationing is defined as 'allocation by the government, free of charge', this system should be considered an unlimited allocation. A crucial feature of this option is that the share of health care expenditures in the GDP can not be politically controlled but rather depends upon the development of medical technology.

We now have to ask whether this rule would be compatible with the principles evoked above, in particular efficiency and freedom:

1. A 'blank cheque' for all health related services can lead to a Pareto efficient allocation only if the utility functions of all citizens give absolute priority to health care in the sense that any two consumption bundles are lexicographically ranked according to the amount of this commodity. The well-known examples of human behavior which is detrimental to one's health clearly show that this condition is not met in the real world. Moreover, given the rapid medical progress and population ageing, the percentage of GDP that can be spent *meaningfully* on health services will increase tremendously in the next decades. On the other hand, it is doubtful if the majority of the population would want to spend the most part of their income just on extending life longer and longer, regardless of how much is left over for maintaining the standard of living.
2. If the condition on preferences mentioned above is not met, then the existence of insurance against health care costs (which, by itself, is welfare-increasing if people are risk-averse and sickness has some random element) leads to the phenomenon of moral hazard in the sense that the insurance distorts the price ratio between health care and other goods and thus induces over-consumption of the former (Pauly 1968). Theoretically, the ideal solution to this dilemma would be an 'indemnity insurance', where the insurance payment depends only upon the type and severity of illness, but not on the consumption of health services (Zweifel et al. 2009, chap. 6). As the health status can not be perfectly measured, a second-best solution to the dilemma seems to consist in co-payment rules. 'Rationing' can be interpreted as a special case of co-payment in a collectively financed

² The well-known American health economist Victor Fuchs (1984) calls the absence of rationing 'presidential medicine'.

insurance plan, in which only two co-payment rates are used, namely 0 per cent (for all services covered by the plan) and 100 per cent (for all other services). Although it is implausible that an optimal insurance contract should specify only these two co-payment rates, one could argue that in the presence of transaction costs such a regulation can be taken as a first approximation to an optimal plan with several co-payment rates.

3. Finally, it is likely that citizens differ with respect to their individual preferences for length of life versus standard of living (consumption level), which implies that they differ in their views on what should ideally be covered by a health insurance plan if they had to pay for the expected costs of the plan. This consideration, taken by itself, seems to suggest that according to the principle of liberty every citizen should be allowed to choose his own insurance coverage. However, the maintenance of a mandatory insurance with collective financing can be defended on distributive grounds: as the only feasible way to redistribute from the good to the bad risks. Hence, there is the trade-off between the principles of liberty and distributive justice, and depending on the relative weights a larger or smaller benefit package of the mandatory plan is optimal.

3. Other Normative Requirements

Before we turn to the central question of justice, we shall argue that a number of other normative criteria should also be met by rationing through the benefit package of a social health insurance.

3.1 Liberty

In a liberal society, the government must acknowledge the different preferences of the citizens. This implies especially that market transactions like the exchange of health care services for money can not be prohibited without compelling justification. This principle applies both to direct health care providers such as physicians in private practice and private hospitals and to suppliers of health insurance contracts. Therefore the benefit package of social health insurance can not be exclusive in the sense that it is legally prohibit to privately produce and trade services that are not included—unless the services themselves are illegal or immoral such as certain kinds of euthanasia. A prohibition on the private purchase of medical services would indeed be futile unless it extended to all non-medical goods and services that are suitable to prolong human life such as healthy food and safe cars.

Moreover it would have to be enforced with instruments of the police state and would still be ineffective as long as the government is unable to prevent private purchase of health care services abroad. A ‘surgery tourism’—analogous to the ‘abortion tourism’ observed between Germany and the Netherlands only a few decades ago—would yield unsatisfactory results in particular from the point

of view of distributive justice, since the high travel costs associated with it make it not only inefficient but have the effect that only the well-to-do can afford to take part.

All these reasons suggest a two-tier system of health care financing in which tier 1 consist of a collectively financed basic benefit package which is ensured through mandatory membership and payment of contributions, whereas tier 2 is given by a free market for private supplementary services and private supplementary health insurance contracts (see, e.g. the bio-ethicist Engelhardt 1986, 361).

3.2 Conformity with the Rule of Law

If the principle is accepted that private purchase of those health care services that are not included in the benefit package of social health insurance must be allowed and that the same holds for supplementary health insurance contracts, then it is a plausible claim that the benefit package itself should not vary arbitrarily according to the situation of scarcity. Only if this basic coverage has transparently specified gaps and limitations, can these gaps be filled by purchasing private supplementary insurance contracts at a time when it is not yet predictable who will need the respective services for a prolongation of his life. This is important because in the presence of risk aversion the coverage through a private insurance contract at actuarial premia is preferred by everybody to the mere possibility to purchase the additional services at one's own expense in the case of need.

Moreover, according to the Rule of Law, the claims and obligations of every citizen against a collectively financed health insurance system should be unequivocally defined so that they can be subjected to scrutiny in front of a court. This very principle would be violated by rationing at the bedside since in this case the insurance coverage by definition does not specify exactly which medical services the individual citizen is entitled to in case of illness. E.g. Höfling (1998, 152) points out that the German Grundgesetz prohibits a delegation of responsibility for life-and-death decisions to the micro level.

By the same token, the much quoted 'prioritization' of certain patient groups or kinds of treatment is not compatible with the rule of law. First of all, the term itself is a euphemism which serves in the political discourse to embellish the bleak reality: what is truly at stake is 'posteriorization', i.e. in times of financial tightness, e.g. due to a fixed period budget certain patients will not be treated, at least not with the medically indicated treatment. The consequence is that the contribution to social health insurance loses its specified *quid pro quo*.

On the other hand, the flipside of a fixed benefit package is that total expenditures of social health insurance can not be determined in advance since somebody must bear the aggregate morbidity risk. If both the benefit package and the contribution rate are fixed, the consequence is either hidden rationing, or physicians must provide additional services free of charge. As they will resist such a solution, this state of affairs can not persist for more than a very short

while. In the long run, a fixed benefit package will mean that the contribution rate to social health insurance will vary over time, which is the price to be paid for the gain in legal certainty. However, it is an open question whether the majority of the citizens is willing to pay this price.

3.3 Efficiency

Finally, in the design of the benefit package of social health insurance, the target of efficiency must not be neglected. This principle requires that for a variety of reasons, not all costs of medical care should be covered completely by the mandatory insurance plan. One of these reasons are administrative costs of processing (small) claims, an even more important one is moral hazard, i.e. the effect of being insured on the incentives for preventive efforts and for the utilization of medical care once an illness has occurred. To the extent that full coverage increases health care utilization, the advantages of risk spreading must be weighed against the disadvantages of a more expensive insurance plan when coverage is increased.

These considerations suggest that the diagnosis and treatment of an illness should be more likely included in the benefit package of social health insurance,

- the more it is life-threatening,
- the stronger its genetic component and
- the less the insured can affect its process through his own behavior.

4. Justice in the Design of a Benefit Package

4.1 Procedural Justice

The well-known medical ethicist Georg Marckmann (2006) has proposed a set of criteria which refer not to the justice of the resulting benefit package itself, but rather to the procedure of designing such a package. This set includes

1. the transparency of the process,
2. the implementation by a democratically legitimized institution,
3. the possibility for important groups of stakeholders to participate,
4. consistency (i.e. equal criteria of inclusion for all types of illnesses),
5. opportunities to appeal.

In this list, requirements no. 1, 2 and 5 appear to be indispensable under the rule of law, although in the status quo (e.g. in Germany), transparency seems to be badly lacking. Requirement no. 3 can be deemed problematic, since it carries the danger of undue influence of well-organized lobby groups. Requirement no. 4 is not entirely procedural but extends already to the material content and thus seems to need a special justification (e.g. equal treatment of different patient groups). Moreover, it seems to be obvious that procedural justice alone does not suffice, but there are certain material requirements that have to be met in the interest of distributive justice.

4.2 Justice and Equality

On a very basic level a consensus seems to be possible that—in particular with respect to state-controlled schemes of resource allocation—justice implies equal treatment of equals under comparable circumstances. However, it is questionable what ‘equal treatment’ exactly means. In the context of the health care system here are several possible reference points:

- a) equality in the formal access to health care services (i.e. absence of privileges for certain groups); this is a very weak requirement, although one that is violated in Germany due to the co-existence of social and private health insurance with different modes of reimbursement of services,
- b) equal chances to benefit from the services of the public health care system: this implies that everybody counts the same in cost-benefit calculations on which the design of the benefit package is based,
- c) the right to achievement of the same result with respect to life expectancy and quality of life (health status), if medically possible: this is the most far-reaching requirement which forces the government to engage in a maximum level of activity designed to even out congenital differences in health status.³

While requirement a) seems to be hardly controversial and requirement c) will be too far-reaching for many, the true problem seems to lie in the operationalization of requirement b), a task to which the next section will be devoted.

4.3 Justice and the Veil of Uncertainty

An instrument used to generate and justify intuitions about justice, which has been well established in many areas of distribution of scarce commodities is the so-called ‘veil of uncertainty’: If I did not know my own health fortune and therefore did not know in which role (as a patient or as a contributor) I would be primarily affected by a particular regulation in social health insurance, what decision would I take in my own interest? The veil of uncertainty tries to solve distributional conflicts by modelling the allocation problem as an *intrapersonal* one instead of an *interpersonal* one. This construction ought to facilitate the finding of a consensus: when everybody is in the same situation, conflicts of interest are suppressed so that the question of justice is reduced to a question of efficiency: Only a solution that is efficient after the veil is lifted can be equitable before the veil.

This procedure can be refined by knitting the veil in different degrees of thickness: in the extreme case, the decision maker is virtually in his mother’s womb and does not even know if he will be born as a boy or a girl. Another important distinction is whether the decision maker already knows his preferences or not.

³ This goal is not meant to imply that people with very good health prospects should be harmed to achieve equality with the less fortunate. On this see the famous ‘levelling-down’ debate, e.g. Brown 2003; Temkin 2003 and Tungodden 2003.

4.3.1 Ignorance of the Own Preferences

In the extreme case, individual preferences do not yet exist, i.e. the decision maker must rely on ‘representative preferences’. For this situation there are a number of plausible decision rules that differ from each other mainly in the kind of risk preferences of the representative individual that are assumed and whether health and consumption are assumed to be substitutable goods:

- a) Without specifying the particular structure of preferences of the representative individual, it seems obvious that *expected utility* should be maximized and that the expected value should be calculated by using the probabilities of the various possible illnesses. However, this approach is still too unspecific to give specific support in the decision whether to include a certain medical service in the benefit package of social health insurance.
- b) If full complementarity between health and consumption and risk neutrality with respect to health is assumed, then utility maximization of the representative individual requires maximization of additional QALYs (‘quality-adjusted life years’) from a fixed health care budget (Bleichrodt and Quiggin 1999).⁴ This is equivalent to setting a fixed threshold value for costs per QALY, which should not be exceeded.⁵ This decision rule seems to underlie current practice in the British NHS. It is based on the implicit assumption that the yet unborn citizen values an additional QALY always equally, no matter in which situation it will accrue to him—an assumption which contradicts not only our intuitions but also wide-spread experience. We know both from theoretical considerations and from empirical studies (e.g. Dolan et al. 2005) that many people care most for an improvement in health when the initial health status is low (e.g. in life-threatening situations) and that health is valued most when there is no general poverty but a satisfactory level of consumption.
- c) If the assumption of risk neutrality in health is replaced by extreme risk aversion, then one arrives at the Rawlsian maximin rule, which implies that help has to be provided first and foremost to those whose health status is worst, no matter how big or small their gain in QALYs is, as long as it is positive. In medical ethics this rule is well-known as ‘rule of rescue’; it enjoys great popularity in situations of triage (see, e.g. McKie and Richardson 2003). It is, however, doubtful if it should govern the design of the benefit package of social health insurance as a whole.

We conclude that the procedure described so far allows specific recommendations on the benefit package only if very special—and most probably unrealistic—assumptions on the preferences of the representative individual are taken. In

⁴ Moreover, the attempt to measure ‘health-related quality of life’ by a number between 0 and 1 is highly debated. One important issue is whether this assessment should be made by persons in the respective health state or by ‘healthy’ persons who imagine being in such a state. On this see Ubel et al. 2000; Nord 2001.

⁵ This rule must be slightly modified if there is a private market for supplementary health care services besides social health insurance. In this case, the absolute level of treatment costs also plays a role (see Hoel 2007).

contrast, if one tried to elicit the actual preferences of real persons, one would encounter severe difficulties since this would require answers to highly hypothetical questions. It is totally unclear how one could motivate real persons to answer this kind of question sincerely and in such a way that the stated preferences had predictive value for real behavior at a later stage. On the other hand, this procedure has the important advantage that far-reaching real uncertainty makes a real (as opposed to fictitious) consensus much more likely than behind a thinner veil of uncertainty.

4.3.2 Knowledge of Own Preferences

In this analysis real persons are confronted with two types of questions:

1. Which share of GDP shall be devoted to the health care sector, given the current state of medical technology and assuming that every citizen will have an equal claim to a share of health care services—in terms of health insurance benefits?
2. How shall the health care budget determined above be divided among the various illnesses, i.e. how shall the benefit package of a social health insurance be designed under this budget constraint? In asking this question, the respondent has to take the probabilities of the various diseases from the empirical distribution of relative frequencies.

This procedure, which could be termed ‘self-rationing’, allows to make sensible reflections even on delicate questions such as different weights placed on services delivered to patients in different ages without raising negative connotations. For suppose the respondent places a higher weight on services for younger patients, then he does so because behind the veil of uncertainty (i.e. before he knows whether he is afflicted by a life-threatening, but curable disease when he is young or when he is old) he takes the avoidance of death at a young age as more important than at an old age—if only for the reason that you do not reach an old age if you have died young because you have not provided for treatment of a curable disease.⁶

There is, however, an ambiguity in interpreting the answers on this kind of questions: Do the answers express what the respondent wants for himself or do they reflect his ‘ethical preferences’, i.e. what he thinks is ‘right’ for society as a whole?

Furthermore, a broad application of this procedure fails due to its lack of practicality: If one wanted to elicit citizen’s preferences for the different allocations of a given total of insurance coverage over the life cycle, one should exclusively ask persons for whom the veil of uncertainty has not yet been lifted—a requirement that can not be met in practice. If at all, then this condition can be fulfilled by young adults who have the largest part of life with all its risks still before them. But even a young person already has certain pieces of information on his genetic endowment and his previous health history so that complete

⁶ This argument is due to the philosopher Norman Daniels (1996).

uncertainty no longer prevails. In addition, questions on the just distribution of health services between children and adults as well as between men and women are, for obvious reasons, not accessible in this way.

A further objection against this type of questions is that serious deliberation on one's own long-term preferences especially on life and death seems to require some amount of experience of life, so that this creates an obvious dilemma: the older the respondent, the more experienced he is and the more able to have formed stable preferences, but the more the veil of uncertainty is already lifted.

Still, this type of questioning has already been used to elicit preferences on the design of specific health care interventions, e.g. by Gyrd-Hansen and Kristiansen (2008). These authors asked respondents if—in case of a serious but frequent disease (myocardial infarction)—they preferred a treatment with a high probability of a small gain in life expectancy or one with a small probability of a large gain.

In Germany this line of research is pursued by the Research Unit 655 supported by the German Research Foundation, which works under the heading 'Prioritizing in Medicine: A Theoretical and Empirical Analysis in Consideration of the Public Health Insurance System' and of which Hartmut Kliemt is a member. One of the primary goals of this research is "to look for prioritizations respecting the interests and wishes of all parties involved, patients, physicians and citizens". It remains to be seen whether this research will focus on self-interested preferences of respondents or on preferences on the allocation of scarce resources among other persons, to which we turn in the next section.

4.4 Just Distribution as Judged by the Unaffected: The Approach of 'Empirical Ethics'

As argued above, concepts of justice which rely on the veil of uncertainty often lack practical implementability. This is also true of Rawlsian concepts in the more narrow sense, which are based on a normatively determined 'veil of ignorance' and not only 'veil of uncertainty'. These concepts try to abstract from direct interests of the evaluator by withholding particular information, but they picture the decision always from the perspective of the participant, not the non-involved third party. This feature distinguishes it from the idea that impartiality of an external observer can ensure the fairness of the judgement: he who is not affected by a decision can be expected to deliver an unbiased verdict. In other contexts, committees are asked to set rules that do not come into effect before the term of the present committee has expired. Quite generally, this conception of the making of fair judgements fits well into procedures that use expert groups to prepare a decision.

The same idea is underlying the concept of 'empirical ethics', which is advanced by authors such as Nord (1999) and Richardson and McKie (2005). This concept has been implemented in a number of empirical studies in which respondents (e.g. regional health service decision makers) were asked to solve dis-

tributational problems which focused on the prioritization of patient groups which differ from each other in certain dimensions, e.g.:

- health status before treatment (on a 0-1-scale),
- the expected gain in health through the treatment,
- age,
- responsibility for own children,
- whether the disease was caused by their own behavior

(for a survey see Dolan et al. 2005). The most remarkable result of these studies was that the decision rule implicitly used differed significantly from a simple maximization of QALYs, as it is obviously intended by the British NHS.

A particularly interesting variant of this kind of studies is the so-called ‘person-trade-off’-method (see, e.g., Pinto-Prades 1997). Here the respondents are confronted with questions like: ‘project A will save the lives of 4 pedestrians in the age group 5 to 15 years, project B will save the lives of 6 car-drivers aged 25-35. Which one do you prefer?’ A large number of binary questions like this allow determining a ‘marginal rate of substitution between saving lives of the two respective patient types’, from the point of view of the respondent. A recent study based on this method (Johansson-Stenman and Martinsson 2008) finds that ‘ethical preferences’ established in this way attached the saving of a human life a value which is decreasing in the patient’s age, higher for pedestrians than for motorists and higher for parents than for childless adults.

Interestingly, however, the authors also find that these pretendedly ‘impartial’ preferences are indeed biased by the obvious interest of the respondent: for instance, the extent to which younger patients are preferred decreases with the age of the respondent, and people with children attach a higher weight to patients with children than do childless respondents. In the same vein, Feuerstein (1998, 195) criticizes that committees composed of physicians and citizens have a bias to decide in favor of ‘people like us’.

While this type of questioning has the obvious advantage of principal feasibility, the equity intuitions elicited in this way can be interpreted as some kind of “ethics from the driver’s seat” (Kliemt 2001), and it is thus disputable whether they should form the basis of political decision making in a liberal and democratic state that is committed to the rule of law: should the government given its financial resources

- a) allocate to each citizen what the majority of the people grants him or should it
- b) take the interests of each citizen as a guideline for its actions?

While Option a) emphasizes the principles of democracy, it has a certain collectivistic flavor and is supported by authors such as Jeff Richardson or Erik Nord⁷ who have a proximity to communitarian ethics. In contrast, Option b) departs from the right of the individual citizen to determine his own fortune as long as he does not impinge upon the rights of his fellow citizens.

⁷ See, e.g., Richardson and McKie 2005; Nord 1999.

One might argue that, if at all, method a) is appropriate in situations in which the respondents do not belong to the group of people to whom the rationing process applies, but are either part of the tax-paying community that sponsors the health services in question or totally unaffected observers. The first case applies to the famous Oregon priority setting process in which members of the community were asked to state their value judgments with respect to the benefit package that the state was to make available to Medicaid beneficiaries free of charge (see, e.g., Garland 1992). Eventually, after the adoption of a priority list, the state legislature increased the funds allocated to this program. This can be seen as an indication of a Pareto improvement being achieved by determining a benefit package according to the value judgments of the sponsors.

However, even the advocates of the approach of ‘empirical ethics’ seem to mistrust the results of their own method, because they see the danger that the respondents exhibit “biased, intolerant and dogmatic preferences” (Richardson and McKie 2005, 272). Therefore they propose to “launder preferences” and to exclude “those preferences that have nothing to contribute to social welfare” in order to determine “acceptable social preferences” and “legitimate social values” (ibid., 273). This proposal obviously begs the question who shall decide which preferences are ‘legitimate’ or ‘acceptable’ (maybe Richardson and McKie themselves?) and, once a satisfactory answer to this latter question is found, why one wants to bother to ask the people to begin with?

5. Just Distribution of Absolutely Scarce Resources: The Case of Transplants

A specific problem is involved in the allocation of those health care goods and services whose quantity can not (at least not without great effort) be augmented, what is true in particular of human transplants. Since these are scarce, patients must die on the waiting list—in Germany every year at least 1000 persons. This constitutes a genuine problem of microallocation which also can not be avoided. It is all the more important for the (potentially) affected people—in principle this is everybody—that the rules that regulate this allocation process are accepted by the population as equitable.

Consider the algorithms of organ allocation which are prescribed by the German Transplantation Act (TPG) and which are applied by the Eurotransplant network. According to §12(3) TPG they reflect exclusively medical criteria, which are

- the urgency of the transplantation for the patient,
- the success probability, as gauged by the blood and tissue compatibility of donor and recipient,
- the waiting time, and
- the country of residence (through the regard to international exchange balances).

Of these criteria, only the first one is genuinely medical, as it is derived from the duty to help in life-threatening situations ('rule of rescue'). The second one is disguised as a medical one, but its justification betrays its utilitarian character, since it originates from the target to gain as many QALYs as possible from a given pool of donated organs. Unfortunately, it stands in stark contrast to the first criterion as patients who need a transplant with high urgency are often already in a bad health status which impairs the chances of success.

The waiting time, however, is a clear case of an equity criterion, which can be diametrically opposed to the 'medical' criterion of maximizing the success probability because with increasing time on the waiting list the success rate falls significantly, in particular for the case of kidney transplants (Meyer-Kriesche and Kaplan 2002). Finally, the observance of international exchange balances can only be justified with criteria of equity: citizens of countries which contribute more to the procurement of transplants (e.g. because of the different national organ extraction laws) should benefit from the pool accordingly. This is quite obviously a non-medical rule, although it is perfectly plausible, because without organ procurement there would be no organ transplantations.

Not only for reasons of providing incentives for donation, but also from the point of view of equity ('do ut des') it suggests itself to apply an analogous criterion to the allocation of scarce transplants on the individual level as well and to take the (previous) willingness to donate of the patient into account.⁸

It is therefore astonishing that the German Ethics Council so vehemently dismissed this idea in its statement on the scarcity of transplants in 2007 (Nationaler Ethikrat 2007). The members of the council argue that it was an established principle of the German statutory health insurance (GKV) that the access to health care should not depend upon the patient's own previous behavior. This line of argument is not convincing since the claim to benefits from the GKV does require a particular previous behavior, namely the payment of contributions. Moreover, there is an obvious analogy between the payment of contributions and the willingness to donate one's organs after death because as much as no health care services can be provided by the GKV without the necessary financial resources by the members, no transplantations can be performed without donated transplants.⁹

6. Concluding Remarks

I summarize my considerations on the application of criteria of distributive justice on the field of health services in eight propositions:

1. Distributive justice in health care is not primarily a matter of micro allocation at the bedside or of 'prioritization'. To the contrary, the room for

⁸ This principle of 'reciprocity' was first developed by Lederberg (1967) and has been vigorously advocated by Hartmut Kliemt for almost two decades. See, e.g., Kliemt 1993.

⁹ For a more detailed analysis see Breyer and Kliemt 2007.

decisions by individual health care providers on the allocation of collectively financed services should be limited to the application of transparent rules.

2. Once a state has decided to implement a collectively financed health care system, it should define the benefit package of this system as transparently as possible. For reasons of scarcity, an unlimited public provision of health care services can not be optimal.
3. In a liberal society, a two-tiers system of medicine—basic services for all, supplementary services for those who are willing to pay for them—is unavoidable. This does not amount to ‘two-class medicine’ as long as every citizen can decide which supplementary services to demand.
4. An enlightened society of the 21st century should have an open debate on the benefit package of a social health insurance.
5. There is a multitude of well-founded concepts of distributive justice. The result does not have to be the one chosen by Great Britain: the maximization of QALYs from a fixed budget.
6. The approach of ‘empirical ethics’ has the advantage of trying to elicit the real preferences of real citizens, but it has certain paternalistic features that are not compatible with a liberal society.
7. A guideline for inclusion in the benefit package of social health insurance should be that citizens wish to obtain these services for themselves.
8. With absolutely scarce commodities (human transplants) the allocation should also take the willingness to provide them into account.

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