Ethical Ambiguities and Economic Consequences in the Allocation of Health Care

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The process of resource allocation, and the necessity of resource allocation, are a fundamental part of the human condition. Decision makers cannot avoid the necessity of making resource choices in health care or with respect to health care in the general economy. Faced with resource allocation alternatives, everyone must make choices amongst those alternatives, and bear the legal and ethical consequences of those choices.

In this paper, I will consider two levels of choice processes: first, choices of what proportion of our total resources to devote to health care and, second, the micro-problem of choosing how to allocate resources within the health care system. These two levels of choice process are governed by a whole range of institutional structures specific to each society, of which laws are only one part. I will consider some of the different mechanisms that society evolves, sometimes deliberately chooses, to try to govern those choice processes, their consequences, and the ethical bases and legal constraints that surround those choices.

The outcomes of the allocation of health care resources turn out to be quite different from one society to another. If we look at such gross measures as the proportions of activity or economic effort that different societies devote to health care, we find they range along a continuum from between 6% to 7% of national income (United Kingdom, Japan) up to 11% to 12% (United States). Canada is somewhere in the middle of that spectrum, grouped with a number of major European countries in the 8% to 9% range (West Germany, France, the Netherlands, Sweden) and then, a number of smaller European countries slope down towards the United Kingdom part of the spectrum. Dramatically different levels of effort arise out of different sets of mechanisms for either consciously deciding, or one way or the other, determining, what proportion of resources to devote to health care. Each society has evolved ways of making these choices that lead to quite different economic results. Nevertheless, health care systems throughout Western Europe and North America actually look quite similar with respect to their technologies and their personnel (doctors, nurses, pharmacists and dentists).

However, the economic consequences of the way they are organized turn out to be quite different. Certainly, complex ethical and legal questions arise from resource allocation decisions with respect to AIDS, surrogate motherhood, and new reproductive technologies. But, along with organ transplantation, their economic consequences turn out not to be nearly as significant as their social, legal and ethical implications. Very often, we tend to focus our attention on these new, complex, or ethically demanding issues and forget the enormous sums of money devoted to business as usual in the health care system.

For example, the rate of production of physicians in Canada is somewhere in the vicinity of just under four times the general growth of the population, and although it attracts less attention, that ongoing process year by year has much larger economic implications than, say, a problem such as AIDS. While AIDS is devastating for particular individuals and extraordinary and dramatic and so on, in quantitative terms with respect to the total dollars spent on health care, it is not as significant. Of course, in making this point, I do not mean to say, and I am not saying, that AIDS is not a significant problem.

I. THE ETHICAL BASES OF RESOURCE ALLOCATION

Health economists make their living by trying to study the organizational structures and processes through which resources get allocated into health care, within health care, and out of health care, depending on the particular specialty they are dealing with. They sometimes hold themselves out as engaging in a form of science, although I am afraid I feel that social science is probably an oxymoron. Nevertheless, people do talk a lot about economic science and, as a science, one would presume that economists were engaged in the development of falsifiable propositions of an "if, then" nature — positive statements like, "if you do this then the following consequences will occur, perhaps with certain probabilities attached to them." Yet, as we all know, a surprising proportion of economists' time is spent making normative statements of the form "you should do X" or, "the GST is a terrible idea" or "the interest rate structure should be raised or lowered and the Bank of Canada should be taking steps accordingly". In other words, economists have a very strong normative bent to their normal activity. As one of my colleagues has put it succintly, "no ethics in, no ethics out". But you cannot make normative statements unless you begin from some kind of ethical base. Indeed, the normative recommendations on policy that economists routinely make, in health care or out of it, are always, and logically must be, grounded on an ethical basis. But describing what you are doing as a science is a relatively powerful way of trying to conceal the ethical basis from the people who are watching, if anybody is in fact watching.

There are several reasons for concealing the ethical basis of your decision. The ethical basis may be unclear; you may be unaware of it; or it might be too difficult to dig down and find out what you really believe in anyway.

Another reason which I think is true of a number of economic pronouncements is that the ethical bases that economists work from are not widely shared. If economists admitted what their bases were, they might not be able to get consensus, whereas if they recommend something without coming clean about the ethical bases, they may be able to get away with it on the grounds that they are actually making a statement of scientific economics. I make this fundamental point not necessarily to cast aspersions on all of my colleagues and leave only myself clean, but to point out that in determining the appropriateness of the ethical base, the economist speaks not as an "expert" but just as another member of the community. My ethics may or may not be superior to yours, but if they are, it does not arise because I am trained as an economist. The expert qualification, to the extent that it exists, has nothing whatever to do with the validity of the ethical positions that econimists take.

This point is quite important, and ties in with our subject of Health Care and Ethics, because the same applies to the providers of health care. The providers of health care in the different disciplines have considerable claim to expertise, perhaps more so than economists. They are accustomed to giving doctors' orders, to making statements of the form "you should do X". On the basis of their scientific expertise, they are entitled to make positive statements of the form "if you do X, then you can expect the consequences to be thus and so". In general, medical science is a good deal farther ahead than economic science, but not nearly as far ahead as physics. There are a lot more openings and gaps in medical science than most people are aware of. But the point is that the scientific basis from which experts speak gives them the right to make positive statements, but not normative ones.

Now, what are the implications of that? For over a decade, we have been hearing all across Canada from representatives of different health care professions, particularly the physicians (but that may be simply because they are better organized), that our health care system is grossly underfunded. That is a normative statement, not a positive statement. It has no scientific ground. Such a statement can be grounded in an ethical logic that says: "there are certain interventions that, if carried out, would lead to the improvement of the health of identifiable individuals and they are not now being carried out because of shortage of resources". That would be a positive statement. The statement could go on to establish the ethical basis: "there is an obligation on the community at large to ensure that those interventions are in fact carried out. That obligation is more pressing than any other obligation that might call on the community's resources". The latter is a purely ethical statement. No one, no matter what their medical or nursing or other expertise, has any special qualification to make that kind of ethical statement.

In such ethical matters, the expert should get one vote like anybody else. But notice I used the word "should" so I slipped into a normative criterion right there. I am suggesting that the expertise that these people claim, like economists, does not bear on the choice of ethical rules. Furthermore, I would also express some considerable unease, although less thought out, about the role of bioethicists. To arrogate to themselves the right to make normative statements on behalf of the community is a very powerful temptation. Bioethicists can help to clarify thinking processes to expose errors of logic and to provide conceptual frameworks. They can provide ethics, but nobody has appointed them as the producers of ethical rules. They are simply expert technicians.

II. THE COST-EXPLOSION/UNDERFUNDING DEBATE

Those who say that the cost of health care in Canada is exploding, or more particularly that it is beyond the capacity of our society to afford, are also making normative statements because, of course, we could well afford to spend a great deal more on health care if we wanted to. The question is really just what do we want to spend, not what should we want to spend. Those who argue for powerful containment of health care costs are probably either rejecting the proposition that there are unmet needs and people's health could be improved if more was spent, or they are rejecting the proposition that there is an ethical obligation to spend more to improve peoples' health that overrides any other obligations.

There are a couple of subsidiary points in this underfunding versus cost explosion debate. One can note, for example, that Canada already has the second most expensive health care system in the world. While we are in the Central European spectrum with respect to share of national income, if you translate that into actual dollar standing, our health care system is more expensive than any of those countries. Not by much, and we remain a lot less expensive than the United States. But, if you argue we are underfunded, presumably you are saying that so is the rest of the world, with the exception of the United States. On several objective measures, it is an interesting fact that the United States has the developed world's least satisfactory health care system. So the notion that "money can buy you love" does not hold up. As a statement about underfunding, the fact that Canada is the second most expensive does not bear on whether we are underfunded or overfunded.

With respect to the "cost explosion" statement, as a proportion of our national income, health spending in Canada was stable all through the 1970s and has been relatively stable ever since the 1982 recession. During the last twenty years, only the period between 1980 and 1982 showed a marked increase in health care spending in Canada as a share of income. Of course, we hear all the dissatisfaction from provinces like Ontario where it appears as if things are coming unglued. In terms of cost explosions, British Columbia and Quebec are much quieter; until recently, there has been pretty good control in those provinces. So, Canada-wide, we are looking at a situation where the aggregate numbers do not support the rhetoric of cost explosion. That is neither here nor there because the cost explosion rhetoric is really a normative statement about what ought to happen, rather than a factual statement about what is going on. Indeed, it is more than that. By trying to worry people about cost explosions you maintain the political constituency for control just as, by trying to frighten people about underfunding, you try to undermine the political constituency for control and obtain more money to plug into the health care system. Both are intended to be self-negating prophesies rather than statements of facts. I must point out that no level of spending or resource commitment anywhere is sufficient to meet all the needs. If that is so, then a strategy or an ethical obligation to meet all the needs makes no sense because it really says society would have to devote all its resources to health care. If the world were different and if there were identifiable points where you could say "this much will do the job and no more is needed", then it would make sense to adopt an ethical criterion of meeting all the needs. Indeed, the founders of the National Health Service in Britain thought that was the case. They turned out to be wrong, as far as we can now tell. An ethical obligation to do what is nonsense seems to me to be self-defeating and internally inconsistent. The lower level, then, is an ethical obligation to respond to people's needs up to some point. That point is a social choice, not an expert's choice. Although you may be sure they will try, experts cannot tell you how far to go.

III. THE ALLOCATION OF RESOURCES VS. THE ALLOCATION OF COMMAND OVER RESOURCES

In the debate over the allocation of resources, we must distinguish between the allocation of resources *per se,* and the allocation of command over the resources. Here, we face another ethical ambiguity.

When we talk about the allocation of resources in economic terms, we refer to the use of "real imports" as we call them: the time, the skills and the energy of people, the services of equipment, the use of facilities, the raw materials, the drugs, all the physical things — the real productive things that go into accomplishing the task. When we talk about health care costs, we usually talk about money. Now, money itself is not particularly productive. The government can always print more of it in the basement of the Bank of Canada in Ottawa, and this is done routinely. You can have all the money you want until you run out of trees to print it on. But, you cannot actually do anything with money. All you can do with money is exercise command over the real imports that do something.

At the level of a society, we are talking about the right of patients, or of people in particular situations, to receive certain classes of services in specified circumstances, and the legally maintained and ethically binding obligations on the rest of us to give up our command over resources in order to provide such people with what is necessary for their health.

At the global societal level, we look at it in terms of real resources transferred from the production of shoes and ships and sealing wax and so on, over to the production of hospital bed days, medical office visits, dental restorations, and pills etc. It is all a physical transaction without the veil of money, as it is sometimes quaintly described, over the surface, confusing what is really going on. That is only a half of the set of ethical issues involved. There is the ethical question of how you decide how much each person gets, who pays, and so on. Those are serious political issues. But, intervening is the obvious fact that there is a whole industry of providers of care who engage in actually supplying the necessary resources and being paid for them in terms of the transfer of command over resources from the payer.

There are the persons who have the right to receive services, and the persons who have an obligation to give up command over resources so that those with the right to receive services may in fact receive them. In the middle are the people who are actually selling the resources. They are giving them to one class of persons, and being paid to do so by another. They have these rights to sell and rights to be paid because of a legal framework peculiar to health care that establishes the special turf of those who sell their resources, resulting in massive turf battles. Turf battles in health care are more extreme than in any other field, with the possible exception of education, although as was best said by one of my colleagues, in the academic field, the battles are so bitter because the stakes are so small. In health care that is not so. The stakes are enormous. Turf battles arise because there is such a complex structure or mix of rights to serve, which have their correlative restrictions or prohibitions on other people's ability to serve, and the right to be paid.

A significant component of the discussion over health costs is not merely what resources are going into health care but also who is getting paid for them and how much. This is an income distribution question, not a resource allocation question. One can imagine, for example, doubling the income of everybody in health care tomorrow. That would enormously increase health care costs but would not actually affect the real resources available to provide health care at all. One could equally imagine halving their incomes. Again, that would have huge impacts on health care costs as normally recorded, but would not, at least in the first instance, have any implications for resources supplied. In the second instance, of course, both of those manoeuvres would have effects on how many people moved into the industry, but that is a second order effect which I have isolated for the moment to make the main point.

A substantial part of what presents itself as debates over the resource allocation process is in fact debates over relative income status. That, of course, has ethical implications, but they are different ethical implications. They are the relationships between the providers of care and the wider society, rather than issues of what is owed to particular patients or individuals in difficult circumstances. Of course, for obvious reasons, these two questions tend to get tangled into one. The fact that how much people get paid affects total costs is, I think, fairly obvious and not one on which I want to spend too much time.

The secondary, more important, issue is "the right to serve". The right to serve issue projects itself in a couple of ways, one of which I have already mentioned, the extraordinary complexity of the turf battles within health care that lead to very large measurable inefficiencies and increases health care costs. This is a problem the world over; Canada is in no way peculiar. Second, the right to serve seems to be translated institutionally into the very important proposition that in health care, capacity creates its own use.

Roemer's Law, formulated by Milton Roemer almost thirty years ago, was that if you built an hospital bed, it would be filled. The determination of hospital utilisation is, how many beds are there? Not what the needs are, nor what the technology is, but just how many beds are there? Roemer's Law has more general application. When it was mentioned that the supply of physicians has been rising four times as fast as the population, you might expect that after some years, there would be some saturation, and physicians would be finding some difficulty in keeping themselves occupied. That has not proven to be so. There is no evidence whatever of saturation or falling physicians' workloads. This is not to suggest that physicians are doing unnecessary things. We do not know that. What we do know is that they are all continuing to remain occupied. Again, this is not peculiar to Canada. There is something like a third more physicians *per capita* in Israel than in Canada. Yet they all remain occupied. They do not make quite as much money, but they all work full time. If the capacity is there, it gets used. This is particularly true if the technological capacity exists, because there are three dimensions to capacity: first, facilities, (beds, machines, etc.); second, people (doctors and other types of health providers); and third, know-how. As soon as we develop new technologies, they get used. To keep a technology under some kind of control, to figure out whether you really need it, to figure out what it is good for, is extraordinarily difficult. Once available, new technologies tend to proliferate out there in the field, and trying to get control of them after the fact is as difficult as chasing a moving target.

Obviously, to develop a policy on capacity, this point about capacity defining its own use is important. But it also provides us with an interpretation of a very puzzling fact. Two constantly reiterated problems for our health care system are the progress of medical technology, and the aging of our population. We perceive these as massive problems for us to cope with, and if you stop and think about it, this is very puzzling.

Technology is constantly adding to our possibilities, our opportunities, our range of choices. How does this make us worse off? Surely we are not worse off through having more choices. Yet we find that when the technology arrives, for whatever reasons, we perceive ourselves as worse off, because we no longer feel we are the ones able to exercise choices. Why is that? Is it because of the ethical implications that the technology brings, or is it because of the structural features of the health industry that lead to decisions being made in a sort of an automatic manner?

The second big problem is the aging population. There again, what would be a better solution? That we all die! Why is this bad news? Because, allegedly, it is going to get so much more expensive to look after all of us as we get older. But obviously a positive proposition and an ethical implication are buried in that. The positive proposition is that as the proportion of aged increases, their needs will remain the same. The ethical implication is that we are ethically bound to meet those needs in the same way and at the same level as we do now. This may be so, and I am not necessarily challenging that, but I am saying that this combination of positive and ethical propositions underlies the great handwringing over the graying of Canada.

However, the aging of the population has been the subject of much study, and research results indicate that it has had very small effects on health costs and is projected, year by year, to have a very small effect for the foreseeable future. Effects of the order of magnitude of 1% per capita per year increase in cost are projected, and this is not devastating. This is well within the capacity of normal economic growth rates. Of course, if you project over 50 years, it looks very big, but then so do normal economic growth rates. My point is that the demographics are not causing us problems. Rather, the way we treat the elderly is now radically different from ten or twenty years ago, and it is predicted that their treatment will be just as different yet again in the next ten or twenty years. What is described as an aging issue is in fact a technology issue under another name. The aging population is the principal channel through which new technology enters the field in a way that has massive economic implications. Of course, new technology also enters the field in all of those fascinating, devilish difficult issues of reproduction, etc. but those turn out, fortunately, not to affect nearly as many people. Aging affects pretty close to 100% of people, so in terms of economic implications, the changes in technology really have their massive effects as they interact with the older part of our population.

The point is, we do not have two issues here, we have one: the appropriate use of technology. What does it do, how do we decide what it should do to benefit society, how do we decide who should receive the benefits, etc., are questions we must address.

IV. AMBIGUITY IN ETHICAL QUESTIONS RELATING TO TECHNOLOGY

Four major areas of ambiguity arise in the way we handle the ethical question of application of technology, particularly to people *in extremis* where potentially very high costs are involved: the elderly, the very young, people with diseases like AIDS, or transplant cases.

A. The Ethics of Uncertainty

The first area of ambiguity is with respect to the ethics of uncertainty. Suppose we accept the ethical obligation to assist, which is presently built into our Canadian Health Care System, of which we are rightly very proud; if you look at what is going on virtually everywhere else in the world, other people do relatively well or badly but we tend to look for the leaders by looking behind us. The ethics of assisting are not the same as the ethics of coping with uncertainty. We have in health care a *de facto* rule that says "when in doubt, do". We could conceivably have an alternative rule that says "when in doubt, do not". Most of our new technologies get applied without any very clear sense or very hard evidence of whether they are going to do any good or not.

For example, 75% of births in Canada are attended by electronic fetal monitoring. Although it is believed by some that this technology does some good, as yet, no randomized trial has shown a statistically significant benefit in terms of fetal outcome. Moreover, because the technology generates false positives, there is evidence that it leads to a higher incidence of Caesarean sections. It is widely accepted that Caesarean section is grossly over-provided throughout North America.

Yet another example is cholesterol screening. Widely and officially promoted in the United States, cholesterol screening can convert 25% of the adult male population of the United States into patients, under continuous monitoring and drug regimens, with drugs that have side effects. But, "it will do wonders..!" It will do wonders all right, for somebody. In Canada, the official studies undertaken on cholesterol screening (I suppose the best one is the study done for the Scott Task Force in Ontario), have decided "do not do it — leave it alone". The data are not good enough, and in the data that do exist, the benefits are not large enough to justify such a huge intervention.

A third example is the coronary artery by-pass, which boomed in North America in the late 70s and in Canada in the early 80s. The proliferation of the technology preceded the performance of any trial that showed any benefit. Now a couple of randomized trials show benefits for a sub-set of the population under very specific conditions, in terms of life expectancy. There are many other results that show improvement in quality of life, but these are also ambiguous. To these examples, we could add others (extra-cranial intra-cranial by-pass being one of them) where decisive randomized trials were done that showed that a procedure was doing more harm than good, and it was terminated.

Why is a high technology procedure used if it has not been demonstrated to be effective? Well, because it *might* be effective! The randomized controlled trial is the gold standard all right, but it turns out to be pretty difficult to do a really conclusive randomized trial. Often, we have a series of partially instructive trials, none of which have a statistically significant findings about the technologies employed. "If it ain't broke ... don't fix it", because fiddling when you are not sure of what you are doing can do harm. Yet, somehow or other, we have backed into this ethical rule of "when in doubt, do ...", not because anybody has agreed to it but because this is what we do, this is how the situation works.

In contrast, the advocates of preventive health care have constantly complained that when they want to do something, everybody says "where is your evidence". In preventive health care, if we do not know, we do not do it. Although it has not presented itself in legal terms yet, there is an asymmetry of onus: in health care prevention, the onus is on those who would prevent the technology from being employed to prove, beyond the shadow of a doubt, that it does not work. This is peculiar. Is there a good reason for that? Nothing immediately comes to mind because technologies do harm as well as good. Of course, we want to try to maintain some sense of balance here. The medical profession is not at all engaged in systematic slaughter of the population; they try to do their best. When a research finding concludes that a certain procedure is harmful, it is remarkable how fast they terminate its use. There are genuine ambiguities, and the professionals who carry out these procedures almost always do them with clear motives. But these underlying decision rules deserve closer examination. The location of onus that we have adopted is not obviously justified by other criteria, at least not that I can see.

B. Ambiguity in the Ethics of Then and Now, or Now and the Future

When we wrestle with issues like "how much money should we spend on health care for the elderly", we are presenting the problem in a "we/they" format, although increasingly it is getting to be a "we/we" format. Deciding what to do about people in a particular class is also deciding what to do for oneself when one reaches that class. The thirty year old who pays the taxes is going to be the seventy year old who is at chance of receiving the benefits. This is as it should be. There is nothing wrong with that, but it also means that it is a rational and indeed ethical decision for the thirty year old to say:

> *I do not want to pay now for something that I will choose not to receive later. I wish to be able to make economic decisions now with full understanding that will deign me later not to receive certain services. There are limits on how much I want spent on me in my declining years, I do not want to find myself working at the poverty line for my entire life in order to be able to pay for an extended and highly technologized old age. This seems like a dumb thing to do.*

The trade-off that presents itself in the present, as the patient versus the rest of society, in the longer time perspective is each of us travelling through the trajectory of our lives. It seems to me reasonable that we should have the opportunity to make those kinds of decisions. What appears as an unethical refusal to assist another person, when one considers it in the short term, may be a perfectly ethical decision for one's own treatment when one consider it in the long-term context of one's own life cycle. But we do not hold discussions in that way. Almost no one thinks or talks in those terms. Yet I believe we must begin to talk that way. The outstanding exception would be somebody like Daniel Callahan in the United States with his books on *Setting Limits*[1] and *What Kind of Life*[2], who says that if we project into the farther future, indefinitely extending life expectancy, indefinitely increasing technology and the ability to maintain life, then we can see, if not now then some day in the future, a situation where we will really find ourselves in extraordinary difficulty, making

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[1] D. Callahan, Setting Limits: Medical Goals in an aging society (New York: Simon & Shuster, 1987).

[2] D. Callahan, What Kind of Life: The Limits of Medical Progress (New York, Simon & Shuster, 1990).

substantial sacrifices in our earlier lives in order to look after ourselves in our later lives in ways which, maybe, we do not think are worthwhile.

Ask yourself how may people you know who want to go into a nursing home. This is a very real question and one that we have not wanted to address.

C. Ambiguity Surrounding the Boundaries of Health

We fully understand that to improve people's health does not simply mean to make them live longer. While improving the quantity of life is clearly an objective, improving the quality is at least as important. We readily recognize as "health care" those techniques or services that repair, reconstruct, cure or mitigate the effects of symptoms and that make you feel better. But, what about services for people with no prospect of rehabilitation — where their underlying condition is not likely to get worse but cannot, in fact, be cured? These people are genuinely in very distressing situations but their situations, are not likely to be affected by health care. Indeed, are the resources rendered to them in fact "health care"? You can say that the services are making them happier, but if you provide me with more resources, you can make me happier too, and I suspect the same is true for most of us. Now this is not to say that I am as deserving as those people, but only that the criterion that we are employing has shifted from "can we improve their health" to "can we make them feel happier in the circumstances in which they find themselves". It ceases to be an argument for cure and becomes an argument that is equivalent to redistribution from the well-off to the poorly-off. It is an argument for a more equalized access to well-being rather than to health care. Those two notions get thoroughly confused, particularly when providers of care want to expand the range of their own services because they know it will make their patients feel better. No doubt it will make their patients feel better, but no amount of expanded resources will cure such people, nor prevent further deterioration. If your business is to make a few folks happier, then that is wonderful, but it is not clear that this is health care and it is not clear that it represents an obligation that the rest of us should support. If it does, why are we not supporting a more general program of redistribution of happiness? You can see the danger I can get into with this line of argument, but it is an important distinction that we need to try to draw. I do not think we do any good by blurring it.

D. The Distinction between Health Care and Health

We know, on the basis of popular wisdom and increasing scientific evidence, that the things that make us healthy extend well beyond health care. Yet, we have assigned a privileged position to health care in our society both because of its extraordinary legal rights and its extraordinary economic rights.

Other factors that determine why some people are healthy while some others are not tend to be much more contentious and much less privileged. We wind up with a bias again in favour of the production of health care, perhaps the most extreme example being all the efforts put into trying to figure out a therapy for lung cancer. There is no therapy for lung cancer, but fortunately it is easily preventable. Stop people smoking. Everybody knows that, and we have known it for years, but it has taken a whole generation to have a major impact on smoking behaviour. It is basically silly to spend a lot of money worrying about lung cancer. It is too late at that point, but health care has the privileged position. Dealing with the smoking industry is so much tougher. Here again, there is a legal issue: when you are in the health care domain, the pathogens do not have legal standing. Very few bugs have been known to sue. The pathogens outside the health care field do have standing. They are tobacco companies, or pulp and paper companies dumping mercury into Owen Sound, or otherwise legitimate organizations in our society with legitimate rights that are in conflict. We evade these issues by providing a special status for health care, but I am not convinced that we have any ethical basis for doing that. It seems to me much more like a kind of retreat of convenience; in a number of significant cases, health care interventions may be a great deal less effective in keeping all of our society healthy than action taken and economic resources spent in other domains.

CONCLUSION

I am not suggesting solutions to any of these areas of ethical ambiguity, and for very good reasons, not the least of which is that I do not have the solutions. I think that what we need to do is, somehow, to begin to open up a debate on them. The debate must encompass definitions of ethical ambiguities in the field of health care, areas where we have implicitly adopted decision rules that tend to exert pressure for expansion of health care, all of which are ambiguous with respect to their health benefits and are profoundly ambiguous with respect to their ethical basis. In the next decade, we should concentrate on trying to dig up the ethical bases of our decision-making in resource allocation in health care, and clarify them a bit more.