Healthcare rationing debate

Commentary on “ The Rationing Debate”, Rationing health care by age

Covering Statement:

This paper aims to comment on Alan Williams’s article of “ The rationing debate [1] ” published in BMJ, 15 [th] March 1997 volume 314. In this commentary I will try to explain different points of argument he raises in his article with the comments on each under the same heading. For the better perception and reflection I will try to suggest an alternative model to his main proposition of this article. The main position of my commentary is favoring the position of Alan about “ Age the criterion to benefit people” I will try to critique him in different aspects of his argument with the induction of my own suggested model and will try to figure out in order to remove the dependency on age for calculating benefit we have to intervene [5] differently with some different aspect.

Rationing debate:

This article is all about the criteria for the priority setting in health care specifically focused on “ Age [1] ” which he mentioned is only the predictor for any health related issue not the cause; he also argued about the main context on benefits extract out of health care in relation with age. In the initial part of his article he tries to figure out the relation between adaptation and adjustment of human body in response to “ diseases”. Here, I want to use more true meaning of this word “ disease” which means not normal, instead of any pathology. He also explains the increased level of risks with increase ages along with more supportive and rehabilitative therapy needed in later ages. Being an “ Old Age Person” he contextualized his argument in

contrast with young age and compares why recoveries are fast in young age and that also the importance of recoveries in young ages.

Up to my level of understanding, his use of ‘ age’ explaining about the different aspects of wellness is more towards own contextualization, being a middle age man I can argue the whole concept of his article in a different aspect and that is level of degenerative changes in human body. Before I explain further I would like to explain a bit about medical notion of generative and degenerative part of Human body. Broadly, our life consists of two major cycles of structural formation i. e. generative and degenerative. Initially we all spent life for the generation of a proper structure of our body including physical and mental construction and then after that we spent rest of our life on that structure, which we can call degenerative part of life. Degenerative part is mainly relying on how well organized generative structure is formed. Up to 30 years of age is considered as a part of generative phase while after that it is all degenerative.

Now I can argue, or suggest Mr. Allan an alternative ground to his concept of Age [1] , which is we will evaluate generative and degenerative health issues to his concept of benefits in comparison of his age based model of benefits. So contextualizing this alternative, infections or acquired disease can be treated as the reflection of body, like in generative phase the estimation of benefits can be different than the degenerative one similarly the developmental disorders. This alternative context can be applicable to public or individuals on the same way like the Age based one; the reflection of body to any external effects.

Desire of Living: Alan uses a term of " vain pursuit of immortality [1] ", desire of living forever which indeed become more important in later ages of life. So as he explains how the outcomes of smaller health related issue considered more in old-aged and why the expectation get higher in this age. He points out the curability or treatability of any health related issue is not the only option in this age groups, there are so many other ways to work in this issue even out of the parameters of health services (like beyond NHS-UK).

Considering the above argument in context with the alternative idea, there won't be any expectation issues because for degenerative un-wellness expectations will be low. The terms of curability and rehabilitation will not be in competition with each other for instance. Ethically it will be easier to justify the alternative one as both the components of this idea are of equal span which will be focusing more on consequences and outcomes; I would not like to say that this will be the maximizing welfare concept or true utilitarian [4] based model except within the degenerative based group benefits of health care issues.

Quality of Life: Other important aspects of his article he suggests about the shift of context from the term of " cure" to " quality of life". He also supports this argument of his by relating it with the values of persons own self-care. Though he stresses that by focusing on quality of life the contemporary approach on new interventions [5] (especially at life threatening levels) will be restricted but still he argues " Quality of Life [1] " is less costly.

The above argument of Alan is basically the further explanation of our context of alternative idea in which regenerative phase is more focused for

the cure with individual choice and distributive to maximal liberty of the individual. Quality of life is only focused to the improvement of degenerative part of health care benefits according to the needs and burdens equalizing resources [4] (egalitarian [4]). So the alternative way can be the modified egalitarian view of health care setting. Being the part of egalitarian nature it can be assume that priority will be set for the high tech innovations in medical sciences which will benefit both the generative as well as degenerative on the same grounds and quality.

Limits: In second portion of his article he tries to explain another aspect of defining limits for the health care benefits, he explains that keeping an eye on this divine principle of " every soul will taste death [2] " it is better to keep a limit before any stress full situation encounters and those limits should be justified on humane grounds according to age, expectations should also be considered according to age. He means to say that age can be considered for benefits though it is not a criterion.

In explanation of above argument to alternative context, expectation will be different for different phases; fulfillment of that expectation would be more justified or in equitable manner. I do agree with this divine principle of life and the relation of its context in our life and building capacity to the alternative way will not effects any change on overall morality [4] of priority health care setting. For this argument I would like to second the thoughts of Alan, health care model should have the parameters for defining the limits in advance, so that the issues like social utility [4] or medical utility [4] could not be raised. The extent of limits can differ in our alternative context of design.

Health of the nation: In the further explanation of his own proposition of benefit related health care objectives when talk about broader view like “ health of the nation [1] ”, he counter argues that this favors against the old age because priorities should be given to those who will benefit more, so the young will get more and also in old age benefits are more diminished and that this is morally unjust that smaller benefits of older should be preferred on larger benefits of young. In support of his argument he explains that older can be considered more beyond the benefit because they have paid more taxes in their lives, but contrarily he replied that usually health care systems are social insurance kind of system in which lucky one gets more. He also supports this argument that elders value more to their small improvements while young focus more to different aspects if talk about their benefits in that case the rationale of health care settings as a social insurance setup will be in jeopardy and private entities will be focus more.

When we deal with the civic virtues and solidarity or community values than the paradigm of priority setting for health care become difficult up to one model application. There are different references points to be deal at this level like, effectiveness, efficiency, legitimacy and distributive justification. If we change the notion of health of nation to the context of alternative idea of this paper than it will be easier to measure effectiveness as regenerative will be given priority. Economically [7] , the degenerative phase will consume more and it will justify the social insurance based argument of Alan that any person who pays in his regenerative phase will get in his degenerative part. Politically, there will be marked difference in both the scenarios. For example, instead of spending major share on long term care facility

government have to build community rehabilitation services centers which will be utilized by all age groups. There won't be any much difference of values of benefits of elders and young, though there will be difference in values of benefits but that will be equitable to widen age groups.

Fair Innings: In later part of the article he explains his proposition as a " fair innings [1& 7] ", in which he tries to explains that any person who lives his lifelong is kind of a fair cricket innings where he plays his innings saving his wicket throughout his life and (using resources of health care for life) build it up till old age (threescore ten is 70 years [3]), while the one who gets out in young age or live a painful kind of life is an unfortunate one and who has been denied opportunities. So the quality of life should be more focused whatever age it is and how many years of life are left.

This argument is almost similar for the alternative context of this paper where someone who spend his regenerative phase of life well and get some tragic death will considered unlucky. So quality of life does not depends on health facilities available, age spans, exposure of the person, economic situations and so many other variant and non-related factors can be considered.

In the end: Concluding his whole proposition, Alan explains that Age is important in determining the benefits and ultimately explains the disadvantages [7] of being elder and low value benefits. As the age increase the value of your benefits decreases. He admits in his conclusion that he would have been preferring younger person benefits [6] over his.

Similarly, age matters a little bit in our alternative model but not as much that it can change the decisions. If our health care system is based on the suggested model of this paper, the criterion for determining the values of benefits would have been very different. Some preference could have been involved due to age but within the rationale of main phase either generative or degenerative.

Conclusion: In this commentary I try my best to reflect my understanding of Alan's debate, although he counters argue his own position many times but within the connotation of Age as criterion to determine health benefits. Reflexivity of his theme can appear to my suggested model of health care setting, where I am trying my best to create a parallel theme to Alan's argument in order to get more grasp on his ideas. Concept of suggested model for health care setting based on generative and degenerative treatments, divine references about death and limits of life is my personal conception and believes. Within the explanation I have tried to create a parallel context for comparison.

References:

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