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# TWO ADDITIONAL OPERATIVE PRINCIPLES FOR HEALTH RESOURCE ALLOCATION ON THE OVERARCHING INSTITUTIONAL AND POLICY LEVELS:

## PRIMARY PREVENTION AND SUSTAINABILITY

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# Most important insight in Torbjörn's book

- Choice of exact ethical/philosophical background theory makes much less difference for how actual (health) resource allocation policy should look like than what (philosophical) bioethicists tend to assume.
- A wide range of otherwise incompatible philosophical outlooks can roughly agree on **practical operational principles for (health) resource allocation** that allow for some variation in practical implementation: **equal treatment, need, prognosis and cost-effectiveness.**
- Due to:
  - Contextual values of importance (eg. legal security and rule of law)
  - Transaction costs
  - Legitimacy
  - Pragmatics
- I will present some ideas continuing this line of thought and addressing high level policy of the kind actualized in large scale, high stakes health emergencies

# Fundamental difference between basic and operational principles

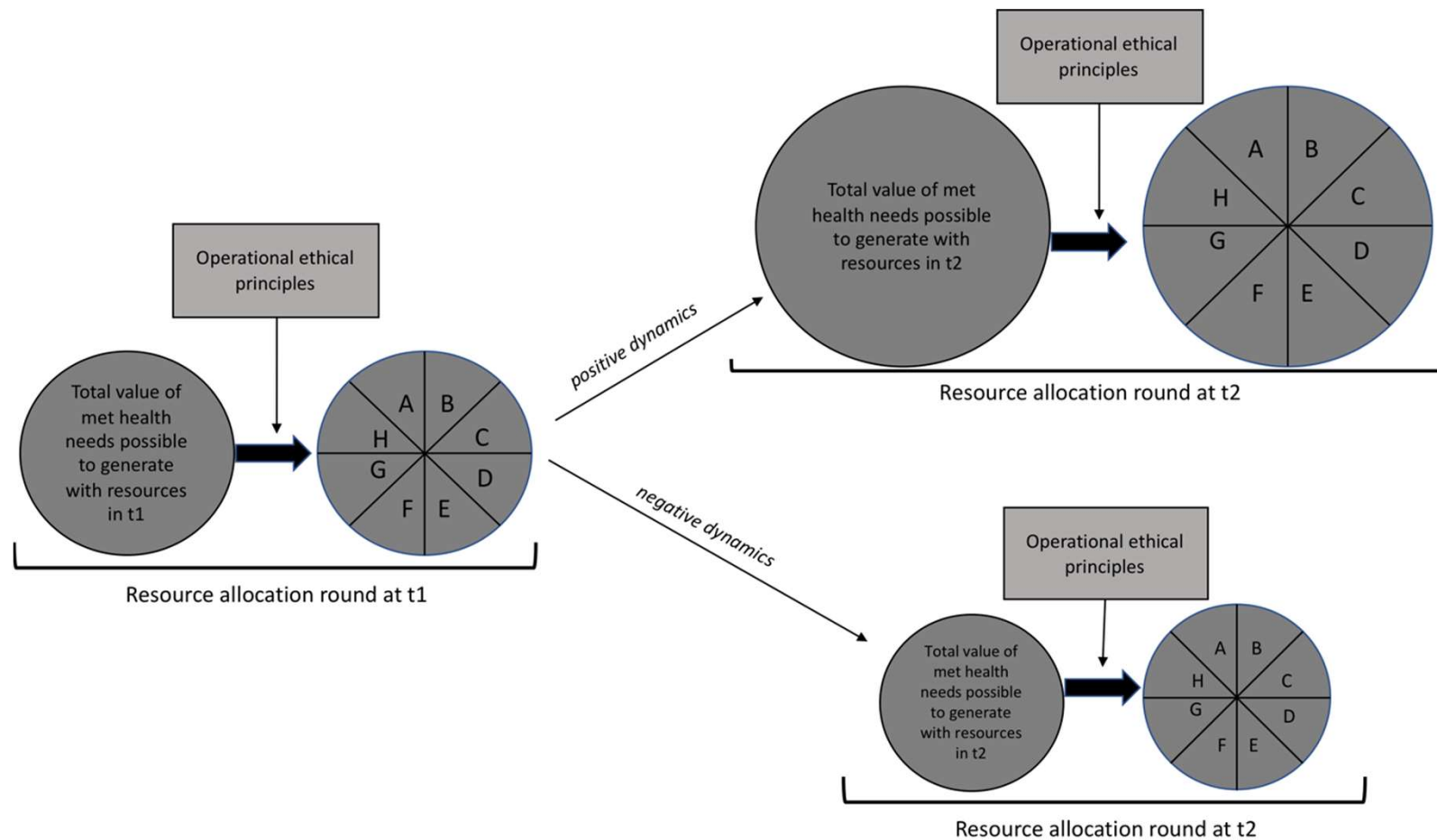
- OPs are discharged in a particular administrative context, bounded by practical limitations and given assumptions, BPs are not.
- Examples:
  - Budgetary and fiscal organisation
  - Established institutional norms for evaluating options
- These may shape the outcome of a resource allocation policy much more than the background BPs thought to be expressed by the OPs.



# Large scale, high stakes emergencies

- Shift ethical focus from **how we slice our pie** of resources and capacities to **the shape and size of this pie itself**
- The better prepared we are and the more capacity we have stored for use in the emergency, the less dramatic are the stakes in slicing the pie we have to face
- But our standard operational principles of (health) policy resource allocation largely fail to capture this shift.

# Example 1: Negative dynamics





# Remedy: Sustainability principle

- If a resource allocation pattern at time  $t_1$  produces negative dynamic effects at time  $t_2$ , this to some extent counts against this pattern at  $t_1$ , and in favour of resource allocation patterns at  $t_1$  with no or weaker negative dynamic effects at  $t_2$
- Can be discharged as:
  - Side-constraint
  - Gradual weight
  - Savings requirement
  - Insurance scheme
- Applications:
  - Antibiotic resistance: environmental dimension management
  - Drug and equipment shortage and delivery insecurity
  - Other systemic spending/allocation schemes undermining the long-term capacity base of health systems

## Example 2: Initial systems vulnerability

- Standard institutional norms for evaluating outcomes prioritize reparation of identified problems over avoidance of possible future problems.
- Due to:
  - Uncertainty of preventive effect
  - Cost of preparedness for eventualities
  - Clinical healthcare ethos as health policy principle: it is better to help a patient than not having any patients
  - Contextual norms: tax ethics, economic evaluation systems, feelings of fairness
- **Increases the initial vulnerability of a health system entering a large scale emergency due to lack of capacity, as "resting capacities" are rather made into liquid resources that are consumed.**
- High (avoidable) initial systems vulnerability is not only bad because of the (expected) damage it may cause, but also **because it is reckless and irresponsible. This ethical flaw remains even if no emergency occurs.**

## Remedy: primary prevention principle

- Sketch: capacities that decrease the initial systems vulnerability should be valued more than the sum of (expected) negative values that lack of these capacities may produce.
- "Unnecessary" preparedness may therefore be worth the cost and be economically justifiable in light of proper ethical principles.
- **How much more** such capacities should be valued can be further debated on the basis of ethical positions regarding decision-making under risk and uncertainty.
- Applications
  - Infrastructure and materials
  - Competence investment
  - Insurance systems
  - Organisation and funding of the health system





# Thank you!

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