Swedish priorities of intensive care during the pandemic – a utilitarian turn or in line with a needs based healthcare?

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The Problem

- In March 2020 I was responsible for developing priority guidelines for distributing the ”last bed” in intensive care at the National Board of Health and Welfare
- We decided on the following priority:
  - When two or more patients have the same severe condition and a similar short term prognosis for being benefited by intensive care – prioritize according to life expectancy based on an assessment of biological age – in other terms – prioritize the greatest patient benefit in terms of life-length gain
  - Criticism 1: not in line with the legal framework – I will not answer that question
  - Criticism 2: risk of age discrimination – I will only touch upon that question indirectly
  - *Criticism 3: a turn towards a utility maximizing decision framework for priority setting (implying a move away from the needs based framework we apply in Sweden)*

The Problem –> my conclusions!

- Is it a turn towards a utility maximizing framework?
- *YES*
  - *It can be*
- Is it a turn away from a needs based framework?
- *NO*
  - *On the contrary – it is required under a reasonable needs based framework*

Example 1

- A suffers from a condition that will kill her in a month. She has a preference for living on. The healthcare can offer her treatment X or Y.
  - X = 3 months survival
  - Y = 5 years survival
  - Which treatment should she be offered?
  - Y
  - Greatest patient benefit = utilitarian rationale
  - A is worse off than she could be = she has a need – Y reduce her ”worse-offness” (severity) more = needs based rationale

Needs based approaches

- Needs-based approaches take interest in patients' starting point – specifically to what degree they are worse off than "something"
  - Worse off than other people in the population – an egalitarian rationale
  - Worse off than some reference level independent of where other people are in the system – a prioritarian rationale

Needs based approaches and the length of life

- A is worse off in terms of life-length – two possible interpretations
  - A has lived for a number of years – shorter than the reference level/ rest of the population – the greater the discrepancy = the worse the condition - highly age dependent - Norwegian perspectiv
  - A has a short time to death – the shorter = the worse the condition – less age dependent – Swedish perspective

Example 2

- B and C both suffer from a condition that will kill them in a month. Both have a preference for living on and are equally bad off.
- Only one treatment Z - this will bring B an extra 2 years and C an extra 20 years
- On the needs based approaches – regardless of in what way we assess being worse off – prioritize C to treatment Z = reduce severity more
  - Reduce the gap in life-length the most
  - Increase the time to death the most

One assumptions you might not agree with

- *More life years for C is better than fewer life years for B – i.e. you can/should quantify life-length gains and make interpersonal comparisons*
- You might instead side with John Harris (1985, 1987) – equal value of lives
- Implication:
  - A = 2 weeks; B = 3 years; C = 10 years; D= 1 month; E= 30 years
  - Should not (have no ethically justified reason) to choose E before A etc.

One assumptions you might not agree with

- Implication for need assessment:
  - BUT – then we have no reason to claim it worse to die within a week - than a month - than a year - than in 10 years or *mutatis mutandis* for length of life in relation to reference level/ rest of population
  - All at risk of dying a premature death wanting to live on = equal need of potential treatment – equal claim to that treatment
  - *Need in terms of life-length as a criteria for distributing scarce resources evaporates*
  - *Only left with QoL criteria (and Harris would question that too…)*

Conclusion

- With a needs based approach to healthcare distribution – worse off is a central concept – and regardless of exact rationale for this we have reason to reduce the severity as much as possible – hence in situations with ”one last bed” and several equally worse off patients – we have reason to prioritize the patient where the severity is reduced the most
- In other words – in the intensive care situation - the patient where we have the greatest patient benefit in terms of life-length gain