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DOSSIER ''CORE VALUES IN BIOETHICS'' /*Philosophical considerations*

A few concerns about bioethics

Quelques préoccupations au sujet de la bioéthique

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Summary Many bioethicists and health policy makers aim to incorporate considerations of *efficiency* and *equity* into their assessments of different health states or policies. I believe they are right to do this. Unfortunately, however, I also believe that there are a number of important theoretical issues that are often overlooked by bioethicists when they do this, and that a failure to adequately address these theoretical issues has significant practical implications for a wide-range of bioethical issues. In this article, I present several of my concerns regarding this matter. In Part I, *Efficiency and bioethics*, I raise some worries about the way in which bioethicists incorporate concerns about *efficiency* into their assessment of health policies and outcomes, by attempting to determine the most cost-effective means of minimizing ill health or maximizing full health. I argue that doing this properly requires us to come to terms with whether our concern about health reflects a fundamental concern about *people*, and/or whether our concern about health represents a fundamental concern about *health* or *wellbeing itself*, and, insofar as it reflects the former, what, exactly, that entails. In particular, I characterize and distinguish between four different positions that might be relevant to our judgments regarding the cost-effectiveness of different health outcomes or policies, which I call *The Narrow Actual-Person-Affecting View, The Narrow Person-Affecting View, The Wide Person-Affecting View*, and *The Impersonal Neutralist View*. Employing examples, I argue that the first view is implausible, but that each of the other three views is plausible in some cases, but implausible in others. Accordingly, bioethicists and policy makers concerned to rank health policies, systems, and states in terms of which are most efficient, will need to determine, for each of the kinds of cases in which we they are interested, how much weight, if any, should be given to positions like The Narrow Person-Affecting View, The Wide Person-Affecting View, and The Impersonal Neutralist View. The implications of my discussion are, I suggest, far-reaching, as ultimately they are relevant to such issues as: the merits of different of health care systems; the treatment of so-called *group I* conditions, which include the communicable, maternal, perinatal, and nutritional medical conditions; issues connected with certain enhancements, including certain kinds of genetic manipulation or engineering at the individual or population levels; reproductive

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issues, including reproductive rights, birth control, prenatal testing, abortion, and reproductive technologies; and epidemiological and population-level health issues generally, including those connected with the social determinants of health. Unfortunately, as my article reveals, getting straight on these matters will require a great deal of complex, abstract, theoretical reasoning. But until these issues are directly faced, and the corresponding hard work is done, there will be reason to worry about any proposed rankings of the cost-effectiveness of different health policies, systems, or states. In Part II, *Equity and bioethics: equality and priority*, I raise some worries about the way in which bioethicists incorporate concerns about equity into their assessments of health states or policies, focusing mainly on the ways in which some attempt to do this by incorporating *egalitarian* concerns, and to a lesser extent on the ways in which some attempt to do this by incorporating *prioritarian* concerns, into such assessments (where *prioritarianism* involves giving greater priority to someone the worse off he or she is in absolute terms). I suggest that some people may be too quick to dismiss the use of egalitarian reasoning in bioethics debates, because they are focusing on philosophical reasons that have no bearing on the *instrumental value* that equality has for promoting positive health states. I also note that most bioethicists seeking to promote equality in health or health care have tended to appeal to a single measure of equality, such as the Gini coefficient, or Atkinson's measure. In so doing, I argue, they have failed to recognize how *incredibly complex* the notion of equality is and, correspondingly, have failed to give due weight to the *many* different aspects that underlay our notion of equality. I also suggest that most standard equality measures yield the wrong answer regarding the impact on equality of proportional increases in a population's size or levels. Following Dennis McKerlie, I argue that, in assessing outcomes regarding equality or priority, there are at least four different approaches regarding the proper focus of our equity concerns that are plausible in some cases and implausible in others—on one of which we assess outcomes in terms of the overall quality of people's *whole* lives, and on three of which we assess outcomes in terms of different *segments* of people's lives. I note that this point, too, has been largely unrecognized or ignored by most bioethicists, casting doubt on the adequacy of their attempts to incorporate distributional concerns into their assessments of different health states or policies. I note that for most egalitarians or prioritarians, there would be no particular reason or justification for ranking alternatives in terms of a single aspect of overall wellbeing, even an aspect as important as health. Worse, I suggest that in many cases efforts to reduce inequalities in health, or to give special priority to those who are worse off in terms of health, will actually bring about a *worse* overall outcome in terms of the most fundamental concerns that egalitarians or prioritarians have. My article recognizes that it is extremely difficult to apply the results of theoretical philosophy to applied domains like bioethics. But I conclude that for a wide-range of important bioethical issues, there is no substitute for doing the careful, thoughtful, painstaking work that is necessary to appropriately take account of the theoretical results, if one is to have much hope of making genuine *progress* on the bioethical issues in question.

MOTS CLÉS
Efficacité ;
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Coefficient de Gini ;
Politique de la santé

Résumé De nombreux bioéthiciens et responsables en matière de politique de santé cherchent à incorporer des considérations d'*efficacité* et d'*équité* dans leurs évaluations de différents états et politiques de santé. À mon sens, cela est tout à fait justifié. Mais je pense aussi que les bioéthiciens ont malheureusement tendance à ignorer un certain nombre de problèmes théoriques importants propres à cette tâche, et que cette négligence a des conséquences pratiques importantes pour un grand nombre de questions bioéthiques. Dans cet article, j'émets plusieurs réserves à ce sujet. Dans la première partie, *Efficacité et bioéthique*, je soulève certains problèmes concernant la façon dont les bioéthiciens prennent en compte des considérations d'efficacité dans leur évaluation des états et politiques de santé, à savoir en cherchant à déterminer la manière la moins coûteuse de minimiser la mauvaise santé ou de maximiser la bonne santé. Je soutiens que pour accomplir cette tâche, il nous faut d'abord déterminer si notre intérêt pour la santé reflète un intérêt fondamental pour les *personnes*, et/ou s'il reflète un intérêt fondamental pour la *santé* ou le *bien-être en eux-mêmes* ; et, dans la mesure où il reflète un intérêt fondamental pour les personnes, ce que cela implique exactement. En particulier, j'identifie et distingue quatre positions différentes qui pourraient entrer en compte dans nos évaluations du rapport coût/efficacité de différents états et politiques de santé :