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Rationing in The Netherlands: The Liberal and the Communitarian Perspective

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Abstract

In the discussion on rationing health care in The Netherlands, a fundamental tension emerges between two ethical perspectives: liberalism and communitarianism. A Dutch government committee recently issued a report opting for a community-oriented approach. This approach proves less communitarian as compared to the views on rationing elaborated by Callahan. Moreover, the community-oriented approach is conceptualised in such a way that it seems compatible with some basic aspects of the liberal account of a just society.

Contemporary ethical debate is dominated by a fundamental tension between two ethical perspectives: liberalism and communitarianism. This tension notably emerges in the debate on rationing in health care and is illustrated by a recent report, issued by a Dutch government committee. This Committee was given the task of considering the question of how a broad social consensus can be found to solve problems of scarcity, rationing and patient selection.[1] In this contribution the Committee's report will be used as a case study to elucidate the fundamental tension between liberalism and communitarianism.

First, I will clarify my vocabulary by determining how I understand 'liberalism' and 'communitarianism'. Next, I will turn to the Committee's report, especially to the so-called 'community-oriented approach' the Committee adopted. After this, I will consider to what extent this approach adheres to a communitarian perspective. Eventually, it will become apparent that the dispute between liberalism and communitarianism is inspired by an even more fundamental tension between two attitudes, which I will refer to as the will to intervene and the readiness to accept. In the last section I will explain my personal position.

Liberalism and Communitarianism

I take 'liberalism' to be the moral perspective which considers the individual as a moral agent who should define his own moral goals and design his personal life plan. On this view, only the individual can determine the extent to which a particular medical intervention will further his plans and goals. Others should not be allowed to interfere with the individual's moral right to self-determination. The role of ethics is not to aim at articulating moral ideas, but to elaborate a set of principles and procedures for the management and regulation of social life.

I consider 'communitarianism' to be a moral perspective which emphasises that the moral agent should not be viewed in such an atomistic way, but rather be considered as situated in a moral community from which he derives his moral identity, his substantial moral convictions and his sense of direction. The moral community

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provides the individual with a moral 'space' in which he inevitably finds himself located, and from which he derives the resources by means of which moral problem-situations can be evaluated. Ethics should aim at developing a substantial ethical consensus concerning the goals individuals should seek to realise in life. On this view the basic factor is not what a particular individual happens to prefer, but rather the question is what his moral objectives *ought* to be. If such a consensus could be found it would provide contemporary medicine with a sense of limit. In other words, whereas the liberal perspective considers the process of devising and questioning life plans the responsibility of the individual himself, the communitarian perspective maintains that these issues should be dealt with by society at large.

The Community-oriented Approach

In the Committee's report, three approaches to the problem of allocation of resources are distinguished: the *individual-oriented* approach (medical intervention should aim at meeting individual needs), the *professional* approach (medical intervention should aim at allowing the individual to function normally), and the *community-oriented* approach (medical intervention should aim at furthering the prospects of the individual to participate in society). In order to realise a system that is fair and at the same time able to contain future increases in health care costs, the Committee embraced the community-oriented approach. On the community-oriented approach health is seen as the possibility for the individual to participate in, and contribute to, social life. A particular medical intervention should count as basic and necessary when it enables an individual to share, maintain, and if possible improve his life as a member of the community. That is: the proper goal of medicine (allowing the individual to participate in social life) is not identified by the individuals themselves, but rather by society at large. Individual preferences and needs should not therefore be given priority. But does this amount to opting for a communitarian, rather than a liberal perspective on rationing in health care?

Is the Community-oriented Approach Communitarian?

At first glance, the Committee seems to opt for a communitarian perspective. The question is what kind of treatment must be considered basic and necessary on a societal level, from the point of view of the community. Thus the Committee's community-oriented approach tries to determine the general goals every individual member of society should seek to realise.

The communitarian import of this view becomes apparent when we compare it to the views of Daniel Callahan who, in the debate on allocation of health care resources, has advocated a communitarian perspective. Callahan writes: 'The goal of health care should be that of helping us to meet our occupational and social roles and duties while, at the same time, helping us to live effectively within the interpersonal sphere of our lives within communities'.[2] It is my contention that the community-oriented approach, elaborated by the Committee, can only partly be considered 'communitarian'. In some respects, it stays within the liberal way of dealing with issues of rationing in health care. I will give two arguments to support this claim. First, the proper goal of health care as identified by the Committee seems quite congenial with the liberal perspective. This becomes apparent if we turn to Locke's original elaboration of liberalism. According to Locke,[3] the liberal perspective is grounded in the notion of consent. A society can only consider itself legitimate insofar as the individuals involved have consented to the way they are being governed. There is, however, an obvious objection to this view. Many individuals have never formally given their consent to the management of public affairs. In order to counter this objection, Locke argues that we must distinguish between 'tacit' and 'express' consent. For although many individuals have never explicitly given their consent, they tacitly consented to it by actually taking part in social life. Locke's account of modern liberal society shows that social involvement is a genuine liberal concern. Should a society exclude a considerable number of individuals from participation in social life, it will find its legitimacy endangered.

Furthermore, there is one particular point where the Committee shrinks back from being

rigidly communitarian. The communitarian approach maintains that questions concerning the good life should not be left to individuals. Rather, society at large should address these issues. But what should count as the good life? Traditional views on human existence often contain some notion of a natural life span. This notion conveys an awareness of the intrinsic limits to human life. At old age, death should no longer be considered a tragedy that is to be postponed at all costs. Rather, death should be accepted as the final chapter of a full and meaningful life.

Such a view has recently been advocated by Daniel Callahan,[4] who is in favour of an age limit to life-extending medical treatment. Society, he claims, cannot afford to continue to provide life-extending interventions to the elderly. Furthermore, a health policy which would award every individual a right to life-extending treatment, regardless of his age, ignores the special meaning of old age in human life. The Committee, however, rejects this view, claiming that it 'would conflict with the universal right to self-determination'.[5] Every individual patient is to decide for himself at what moment his life can be considered complete. On this issue, the Committee clings to a liberal perspective on health care.

The Will to Intervene and The Readiness to Accept

It should by now be apparent that behind the dispute between liberalism and communitarianism there lies a more fundamental tension between two different attitudes towards illness, impairment and death; or, to put it in more general terms: towards the limitedness of human life. On the one hand, human beings seem motivated by a natural impulse to intervene when ill health impedes the realisation of important life goals. The most rigid version of the 'interventionist' view contains the claim that all aspects of human life can and should be controlled and manipulated in a rational way, in order to further general human well-being.

The life span concept, on the other hand, is an interpretative tool that tries to fit the events of a life time into a meaningful pattern. As such, it conveys a sense of limit. Communitarians like Callahan emphasise the importance of our readiness to accept, especially at old age. According to Callahan, an age limit to life-extending treatment is acceptable, provided that age is viewed as a *biographical* datum. At a certain point in life, the individual has had the opportunity to realise his goals, while unrealised goals have been set aside as unrealistic. At this point, death becomes acceptable. That is: Callahan uses the life span concept in his effort to check the inclination to intervene, which dominates contemporary medicine.

Furthermore, he maintains that the will to intervene is encouraged by the individualist and liberal ethic that dominates contemporary moral debate, especially with regard to health care issues. As soon as a particular life-extending treatment is available, the individual physician will be inclined to use it, and the individual patient will claim a right to it. The will to intervene can only be curbed, he claims, by public effort on a societal level. Death beyond a certain age will only become acceptable if it is accepted by the majority of individuals in society.

At first, Callahan was reluctant to identify the life span with a particular calendar age, recognising the considerable differences in health that exist between individual patients of the same age. In 1987, Callahan is in favour of taking individual differences into account. In 1990, however, he writes: 'That was a mistake ... I would now say that, to be consistent in the use of age as a standard, no exceptions should be made'.[6] Only categorical standards, formal and impersonal, applying to all, determined by society and not dependent upon subjective and uncertain clinical evidence, can effectively be used.

Evaluation

In my view, we are faced with two seemingly incommensurable truths. The first moral truth is that it is both possible and admissible for individuals to try to manage their own lives. The second truth is that our efforts to intervene and manipulate are nevertheless restrained by intrinsic limits. One of these limits is the sense of finitude the life span concept tries to capture. Every sensitive solution to the rationing problem must take both truths into account. They provide the two-dimensional moral space within which moral deliberation on allocation issues take shape, and within

which every contribution to the debate—whether of a more liberal or of a more communitarian persuasion—can be situated.

If the life span concept is translated into an age limit for life-extending treatment, as Callahan would have it, too much weight is attached to our readiness to accept, while the legitimacy of our will to intervene is being neglected. In Callahan's proposal the age limit functions as a categorical standard. Life-extending treatment is denied to the elderly patient, regardless of individual biography or physical condition. In my view, however, the life span concept should not serve as a categorical standard for *public policy*, but rather as what Callahan elsewhere[7] refers to as an ideal for *moral policy*. A moral policy provides a general direction of thought and action, a basic framework for making specific decisions. Although it tries to express and affirm a substantial view on human life, it does not map out in advance the exact choice to be made in each situation. Instead of providing an impersonal standard, it allows room for prudent deliberation in specific cases.

The Committee on the other hand, merely restricts itself to criticising Callahan, and does not form an alternative, specific moral policy. It fails to outline the role age should play in health care choices. While allowing every individual the right to determine his own life, while granting every elderly patient a basic right to medical intervention, the Committee fails to explore what I referred to as the readiness to accept.

It is my contention that an ethical contribution to the debate on choices in health care should be devoted to the elaboration of a framework for prudent deliberation on an individual level, in which justice is done both to the readiness to accept and to the will to intervene. A medical intervention is misguided if it interferes with the individual's efforts to fit the events of a life time into a coherent pattern. In the life history of an elderly patient a point may emerge where the inclination to intervene should give way to the readiness to accept.

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