

on psychogeriatric patients', *Journal of the Royal Society of Medicine*, 77 (1984) 840–844.

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## Medicine in Society

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J. Harris, 'QALYfying the value of life'. *Journal of Medical Ethics*, 13 (1987), 117–23.

Medical care has always been unlimited for those who can pay for it. When costs have to come out of the public purse politicians become concerned about value for money and allocating priorities between different services and categories of patients. These priorities have traditionally been held to be matters for political decision, but politicians are attracted by arguments that offer to turn difficult political issues into technical ones soluble by the application of plausible formulae. The present fashion is for American politicians to seek formulae from ethicists, the British from economists.

One traditional form of economic argument in health care, which has spawned many variants, is to weight priorities in proportion to the number of years of life expectancy saved for the recipients of specific interventions. On this reckoning a scarce life-saving treatment should be given to younger patients in preference to older since younger patients will, on average, have more years of life expectancy left. One of the more pernicious variants of this approach is to count only those years preceding compulsory retirement age on the premise that the worth of man is to be equated with the potential value of his labour to the state.

Recently, British health economists have imported the American concept of the Quality Adjusted Life-Year (QALY) in a laudable attempt to incorporate some assessment of quality as well as length of life into the evaluation of care outcomes. The QALY aims to weight years of life gained or modified by a health service intervention on a scale of zero to one. Thus one year of perfect fitness, weighted at 1.0, would be regarded as worth two years each weighted at 0.5 because of some disabling or painful condition. It is even possible to envisage negative values to certain states of existence that match the Victorian heroine's concept of 'fates worse than death'. A simple refinement would make it possible for the QALY to reflect outcome probabilities,

and so reflect the dangerousness of different interventions as well as their benefits. The QALY is undoubtedly a valuable concept in illuminating some of the problems in making decisions in health care, but some of its implications and the practical uses to which it might be put are being increasingly questioned on ethical grounds.

In his comprehensive critique, Harris points to the crucial issue that although a QALY count may be an appropriate way to decide which of two treatments to offer to an individual patient, and even better which of two treatments the patient should himself choose, it is wholly a different thing to use QALYs to decide which of different patients should be given treatment in preference to others. For one thing, to do so begs the question of whose QALY ratings of different health states it would be appropriate to use. There is evidence in the literature, for example, that people who have kidney disease put a higher value on the outcome of dialysis programmes than do people who do not have kidney disease. There will be social class and other cultural differences in the values put on life-years spent with particular disabilities. The suggestion made by some health economists that QALY values could be determined from the answers to questionnaires administered to representative samples of the general public, despite its veneer of democratic form, seems either naive or sinisterly disingenuous. The QALY approach to allocating care between different groups also makes the assumption that the life-years of different individuals are equal in value. Perhaps they are in the eyes of the state but many would argue that the value of a life can only be assessed by the individual living it, and that therefore it is logically impossible to make any value judgement on the relative worth of  $x$  years of Mrs A's life compared with  $y$  years of Mr B's. By this reckoning, all people are of equal, because of indefinable, value.

The QALY is inevitably ageist, and Harris points out that since expectation of life varies with sex and race, if consistently applied it would also be sexist and racist. One could also note that expectation of life varies with social class and while the assumption of the Black Report was that resources should be diverted to the lower social classes where health and life expectancy are poorer, the QALY would prescribe priority for the longer-lived upper classes. Harris identifies this as a problem of the double jeopardy produced by using QALY's for allocation of priorities; those who have the worst health will in consequence be allocated the poorest care.

Harris argues, as have other recent commentators on the QALY, that if equality of citizens is indeed the ideological aim of our western societies, life-saving and life-enhancing resources must be allocated in

ways which do not violate the individual's entitlement to be treated as the equal of any other individual in the society. This is in fact the ethical principle underlying that fine old British institution the queue, but the radical suggestion of a lottery (suggested elsewhere by Harris) also merits serious attention.

The attraction to politicians of using life expectancy, in whatever form, in the deployment of health care resources is the idea that the government will thereby get value for money in terms of the numbers and fitness of the governed. But this is value perceived primarily from the standpoint of the purveyors rather than of the recipients of health resources. There is, for example, shopkeeper's logic in the implication of some proposals for the use of QALYs in the allocation of health service budgets, *e.g.* that because QALYs obtained from anti-smoking propaganda are cheaper than those obtained from renal dialysis or hip replacements the latter two services should cease entirely in order to provide funds for the first. This would only make sense to shopkeepers; Harris asserts that the obligation to save or improve as many lives as possible is *not* the obligation to save as many lives as we can either save or improve cheaply or economically. The health budget is limited only by political decision. He suggests that efforts expended on trying to measure the value of people's lives and select those worth helping would be better devoted to an examination of the national budget to reassess the priorities being given to expenditures under heads other than health. The QALY is unmasked as a device that could be used to let government abrogate its moral responsibilities and to distract the public from noticing.

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