Ethical Viewpoint Paper

Health Care Rationing: An On-going Ethical Dilemma in India

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Introduction

Healthcare rationing for elderly is an unfinished agenda in bioethics. It has gained momentum in recent years especially in resource-strapped country. More than two decades ago, Callahan in his highly controversial book, Setting Limits: Medical Goals in an Ageing Society [1] argued that expensive medical aid needs to be prudently decided and rationed carefully for the elder members. Even earlier to this, Veatch [2] had made a strong opinion of favoring younger population over elderly group in resource allocation. With rise in average life expectancy, burden of chronic and intractable diseases too has increased. On the other hand, there is an ever increase in the healthcare resource cost, socio-economic rift between rich and poor and population growth. These factors make it formidable to discuss healthcare rationing.

Hospitals, across the world are already under pressure of huge patient influx, majority of whom are elderly, chronically ill and dying. The emergence of COVID-19 pandemic in December 2019 has crippled the healthcare system even more. In India, healthcare institutions are already facing challenges in balancing issues around ethics, economic efficiency, universal access, and delivering medical services. In the present context, where health indicators are poor, the issue of ethics becomes more complex and requires a nuanced understanding and appreciation of the social predicaments. At present inequality in access to healthcare, unequal distribution of healthcare facilities, privatization, and corporatization of healthcare, overpricing of medical interventions and unnecessary prescription of drugs and procedures to inflate the costs, by private hospitals and doctors, lack of quality healthcare professionals in rural and backward areas, issue of granting and extending patents; evergreening of patents, etc., issues related to disclosure of information to the patient and the caretakers, ethical issues like euthanasia; abortion, etc. are some of the burning issues. The present pandemic situation has foregrounded these issues that have plagued the healthcare infrastructure. A rarely discussed but old discussion came to the forefront of all medical discussion i.e., rationing in the provision of healthcare. A video titled: "Doctors Face an Impossible Choice When Rationing Care" published by Time discusses the same issue and asked an important quest why a woman suffering from cancer should be getting treatment when her before the covid situation is even worse than her post covid situation. Similarly, when COVID-19 death rates peaked in Italy in March, TV channels around the world flashed horrific images of desperate patients lined up in hospital corridors awaiting admission, patients laying outside the hospital buildings, overworked healthcare workers triaged the arriving rush. They had to extemporize on their feet, knowing fully well that some of those sent home would die but still they had to do it.

The COVID-19 in India picked up considerably late after May but sparked similar fears of a cataclysmic crisis owing to poor health infrastructure. The largely poor living conditions and the density of population were worrisome situations. In metro cities and a few states such as Delhi, Kerala, Maharashtra, Gujrat, West Bengal, Madhya Pradesh was some of the worst-hit parts of

the country, ventilators, ICU beds, nurses, doctors, and medicines were all in short supply at different points. Some patients died while shuttling from one hospital to another in search of a bed. Video and the news that aired during that time some of the fearful news of all times where patients were helpless, and no one is there to help them. But fortuitously, many of our worst fears have not come to pass – perhaps more due to timely reaction to the crisis, Demographic dividend, and one of the strictest lockdowns, since the fatality rate in India has been lower than expected. Considering the population of India which 1.3 billion where more than 70% of the population pay out of pocket for their healthcare expenses choose to go to private doctors rather than an underfunded and overcrowded health care infrastructure. Doctor: population ratio of 1 in 1000 is very uneven concentrated mainly in urban areas and the government spends only 1.5% of its GDP on healthcare. With ongoing debates happening everywhere India also imported these debates of Healthcare Rationing in India to and research [3] discusses the applicability and implementation of rationing in the Indian context. There are many facets to these discussions, and it has started long before COVID-19. Proponents of these, ethicist Daniel Callahan has argued that expensive medical care is parceled out carefully – essentially rationed – for elderly patients in his book, "Setting Limits — Medical Goals in an Aging Society." he made the case for limitations on care based on age.

Cohen [4] attempts classifying healthcare rationing into three overlapping themes, as found in academic discourses:

- Define rationing and resource allocation, with an emphasis to understand the methods for accomplishing them [5-9].
- Conceptualize rationing as a cost containment tool to stem rising health care costs [10-15] and
- Promote rationing as an ethical policy to assure equitable allocation of resources [16-18].

Justifying the Limits

Those, like Callahan, who supported his suggestions to rationing health care and medical resources based on age believe that such a system would bring about the greatest good for the greatest number of people. The health of the young can be ensured by relatively cheap preventive measures such as exercise programs and health education, but for the elderly medical condition are often complicated, requiring the use of expensive technologies and treatments and often, these treatments are ineffective in providing any tangible benefit for either patient or society. In a nutshell, the costs incurred to cure one elderly person might be more productively directed toward the treatment of a far greater number of younger persons whose health can be ensured by less costly measures. Moreover, the advocates of this system argue, society benefits from the intensification in economic activity that is directly proportionate when medical resources are diverted from an elderly, retired population to those younger productive members of society. Supporters of age-based rationing don't see unjust in withholding medical treatment from the elderly population.

Against Rationing

There is dissent in arguments offered by the advocates of health care rationing. The claim by advocates that rationing would bring balance and benefits for society is contested by those who argue that any rationing policy deprive the old age people of life-saving medical care would result in enormous costs and few benefits. For the young, such a policy would lead to sharp levels of apprehension and fear as they grow old, while the elderly, not wishing to die and feeling abandoned by society, would despair. Moreover, if monetary benefits were achieved by rationing care by age, there's no guarantee, given our present political system, that any savings on the old would be directed to the young. The actual benefits would depend on what kinds of resources were transferred to what sorts of treatments. The opposition of health care rationing by age argues that such a policy would violate our moral sense of respect for persons and respect the fundamental dignity of persons.

However, I feel it would be an interesting exercise to see if equitable rationing can be implemented. It is recommended allocation of limited resources be aimed at both saving the greatest number of lives and at maximizing improvements in the individuals' post-treatment length of life. But it would be a question for debate in a situation when two people of a family come, and one is the chief wage earner and another person is the son of that person in his 20s. It is a very difficult ethical choice to imposed rationing decisions, the overall health care infrastructure must be efficient and proactive, so that need for rationing can be minimized. By reducing medical waste, containing medical corruption, promoting best practices, and eliminating medical errors, we can reorient healthcare expenditure for betteruse. The healthcare resource is finite but the demand for costly new treatments is growing rapidly. We need to focus and optimize healthcare allocation. To minimize rationing and mitigate benefits to a possible extent.

Conclusion

Within this debate for and against healthcare rationing there is a room for human compassion. The article ends with two cases: one, an Italian priest, aged 72 years, contracted coronavirus on March 2020. However, he died after he gave up a ventilator so a younger patient survive. According to a healthcare worker, the priest was given a ventilator, but he refused it. According to Vatican News, greeted everyone with the phrase: "Pace e bene." Clara Poli, mayor of Fiorano said, "He was a priest who listened to everyone, he knew how to listen, whoever turned to him knew that he could count on his help,". In contrast to the first instance, the second one revels how WHO director-general appealed to richer and developed countries to postpone vaccination of their children and donate the jabs to poorer countries, who so far are deprived (Hindustan times, 2021).

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