BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

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In this issue

- Our leading article in this issue is a history of the debate about how health care resources ought to be distributed. The author is Mr Keith Joseph. Keith is a PhD student in philosophy at the University of Newcastle. His thesis, on the ethics of human genetic engineering, examines the usefulness of the theory of consequentialism for evaluating genetic research. Keith joined us - as a part-time member of the John Plunkett Centre - in September. His research project with us is the development of a virtues-based approach to justice in the allocation of resources.

- The elderly make up one of the groups most at risk of injustice in the distribution of health care resources. (For instance, one of the reasons advanced in favour of the legalization of euthanasia is an economic one: it is said that in the future we will not be able to afford to care for all the demented elderly.) In his review of Harry Moody's new book, ***Ethics in an Aging Society***, John Quilter addresses the difficult issue of inter-generational equity.

- On a different subject, Gerald Gleeson discusses some ways in which the well-known principle of the double effect may be misunderstood. He outlines an argument in favour of a "taxonomic" rather than a "geometric" understanding of the principle.

Health Care Resources: a history of the debate

Keith Joseph

In 1991 a booklet entitled *Health Care at any Cost?* was published by the New South Wales Health Department. The booklet was notable not so much for its contents as for its general theme. It gave official and public recognition to the fact that the health system of New South Wales simply does not have the resources to meet the demands that are being placed on it.

There are many reasons for this problem. Firstly, there are the new technologies which occupy so much of the public's attention. They certainly expand our ability to provide good health care, but simply by being available they increase the demand for their use in health care. Satisfying this demand (especially with expensive technologies) comes at a cost. Secondly, an increasing percentage of our population is over the age of 65 years old: this is expected to bring with it increased health care costs, as the elderly consume more health care than younger members of the population.

All this comes at a time when the economy is in prolonged recession, and future economic prospects are uncertain. The revenue base of

government (especially at State level) is therefore relatively static, and the demands upon government finances for items such as welfare are increasing. It is not surprising therefore that governments are keen to reduce expenditure, and are certainly not prepared markedly to increase expenditure in areas such as health.

These factors are not unique to Australia - indeed, we are in a similar position to most other western democracies. Like them, we are going to have to make hard decisions on the allocation of health care resources. These decisions have an ethical sting, and they have provoked much debate. In this paper, which is the first of a series of papers on the ethics of health care resource allocation, I briefly examine the history of this debate, and outline some main issues in that history.

Triage

Debate on the allocation of limited resources is not new. In medical ethics discussion used to focus on the wartime experience of *triage*, in which a sudden demand for medical services (for example, after a major battle or a natural disaster) overwhelms the resources available, and the treatment of patients must be prioritised. In *triage*, the increase in demand is sudden and temporary, and there is no capacity to restructure or increase the supply of medical services. This contrasts with the present situation where we can foresee a long-term, steady increase in demand, and we can alter the structure and pattern of supply. This type of allocation - that of determining which individuals ought to be allocated health services - is a form of what can be termed "micro-allocation". In contrast there are issues of "macro-allocation" - how should society distribute its resources? This, too, is not a new issue: the debate between socialists and capitalists has been going on for more than a century!

Eugenics

In health care an early manifestation of concern about macro-allocation can be found in the eugenics movements of the late nineteenth and early twentieth centuries. Eugenics was concerned with the elimination of undesirable genetic traits (such as "feeble-mindedness") for the benefit of society, families and individuals. Whilst economic considerations were not a prime concern, nevertheless it was thought that a significant benefit of eugenics would be the reduction of demand by the genetically unfit upon the state and other charities for health care.

Eugenic theory had lost much of its attraction by the 1930s, and with the holocaust of the Second World War it was eclipsed. However, in the reconstruction period after the war there was a new emphasis on macro-allocation, with the shift of many Western democracies towards either a nationalised health service or a form of universal health insurance.

Importantly, the United States has resisted this trend, partly because of a firm belief in the virtues of the free enterprise system, and partly because of American suspicion of bureaucratic and government interference in the lives of individuals. The contrast between the American experience and that of other western nations such as Australia has had a very strong influence on debates on the ethics of health care resources both at macro- and micro-allocation levels. In the two decades following the second world war, health care in western societies, both socialist and free-enterprise, continued to improve. However, in the 1960s new technologies began to be introduced in ways which greatly increased the cost of new forms of care. It was at this time that the new debates about the allocation of health care resources began.

New Technologies, New Problems: the 1960s and 1970s

The first notable example of the problem of resource shortage related to new technology occurred in 1960. It concerned the use of renal dialysis at the Seattle Artificial Kidney Center. Simply put, there were far more potential recipients than machines available. The response was to set up what was arguably the first institutional ethics committee composed of "physicians, members of the hospital staff, and lay members of the community".[1] Their task was to select who would receive treatment on the machines. Who was to benefit from the limited resources available? Who would live

and who would die? The criteria used were those of social worth - the committee took into consideration age, gender, occupation and marital status, and at one stage even solicited letters from neighbours and employers.[2] A story in Life magazine in 1962 about the committee aroused much criticism of the way in which the dialysis machines were allocated. Eventually, in 1972, the US Federal Government, in response to these problems of selection, made renal dialysis universally available. This story reveals much about the underlying approach to problems of resource allocation in the "early" period from 1960 to the mid 1970s. A problem was identified: a technology was available (in this case, renal dialysis) which was very expensive and thus beyond the means of individuals to pay for the technology. The local or state community then became the provider but, due to the expense of the technology, was unable to provide for all those who needed it. The response of society then was to throw money at the problem: to provide the resources so that rationing need not occur. In this case the US Federal Government picked up the bill - and the cost of renal dialysis exploded. "Estimated to cost no more than $50 million at its peak, renal dialysis now [1987] costs taxpayers almost $2 billion per annum, for 75,000 patients."[3]

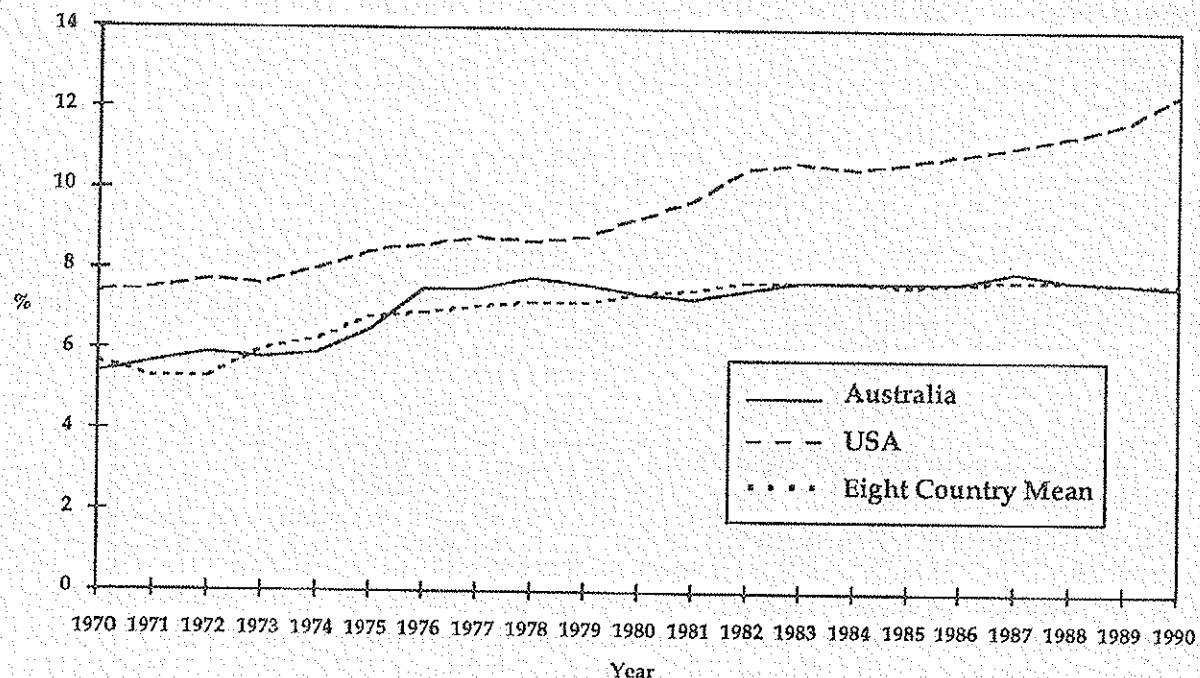
The emphasis of debate at that time was on the basis for micro-allocation. Was the present or future quality of life of patients relevant in choosing those who should receive transplants? Or was it to be on a first-in-line basis? However, as long as the government and private insurers were willing to pick up the bill, macro-allocation issues were not of great prominence.

Macro-Problems, Micro-Solutions: the 1980s

The 1970s and 1980s saw a period of rapid increase in the cost of health care in the western nations of the Organisation for Economic Co-operation and Development (OECD). The graph below illustrates this well, showing the percentage of Gross Domestic Product spent on health care by Australia (solid line), the United States (broken line) and the average for eight comparable nations of the OECD (dotted line) for the period from 1970 to 1990.[4]

There are three notable features. Firstly, these figures are huge in comparison to spending on health in the developing world. When we talk about problems in the allocation of resources in the West, we are dealing with the problem of what to do with our wealth, rather than grappling with stark poverty. For example, in Zaire the budget allows 16 cents per person on health care per year[5]: in Australia expenditure is over $1,700 per person per year[6].

Total Health Expenditure as a Percentage of GDP



Secondly, in Australia and the other OECD countries there was a period where expenditure as a percentage of GDP levelled off in the mid 1980s, though it has started increasing again. Finally, the United States is spending far more on health care than any other comparable nation.

The situation in the United States is made worse by increasing inequity as well. Unlike other most OECD nations the United States does not have universal health coverage: rather it has a mixed system. Wealthier citizens have private insurance: private insurance also comes as part of the wage package for most jobs. Medicare covers those over the age of 65, and the very poor are covered by Medicaid. A few items, such as renal dialysis, are covered universally. However, there are about 35 million US residents who do not have insurance, are not old enough for Medicare, nor poor enough for Medicaid. These people effectively have no access to medical services, apart from state or private charity. It is not an exaggeration to describe the US health care system as being in crisis; thus the attempts of the Clinton administration to address the problem of health care financing and allocation.

It is no surprise therefore to find that the debates about resource allocation in Australia are dominated by American ideas. Some of the debate in the United States is based on a solid critique of their present system, and would seek, for example, universal health insurance. However most of the debate seems to aim at reforming the present system, either through more just and equitable micro-allocation, or through more efficient use of existing resources. These lines of thought can be seen in some of the proposals to emerge in recent years, especially in the developing use of Health Maintenance Organisations (HMO) and Diagnosis-Related Groups (DRG).

Health Maintenance Organisations

Health Maintenance Organisations work as a form of insurance. Consumers pay the HMO a flat fee, for which the the HMO agrees to provide them with treatment for agreed conditions for an agreed period at no extra cost to the consumer. Obviously, there is a strong incentive for the HMO to provide services at the lowest cost possible: however, there is also a strong incentive to under-service consumers, and to refuse to treat certain conditions or patients. For example, psychiatric conditions are sometimes excluded from the HMO agreement, and those with chronic conditions may find it hard to gain membership.

Diagnosis-Related Groups

Diagnosis-Related Groups are groups of conditions for which the average cost of treatment is determined: for example, a hernia operation might be found to require, on average, hospitalisation of 3.8 days at a cost of $2,333. Originally DRGs were intended to be used for audit purposes: with them it could be determined, for example, if a group of patients deviated from the norm for a given DRG, and then action could be taken to check or correct that deviation. However, they are often made the basis for funding: hospitals or health professionals are reimbursed not for the services they carry out, or on the basis of historical budgeting, but on the basis of the DRGs they treat. In such a system there is great incentive to cut costs to maximise one's surplus - but there is also a great temptation to diagnose patients as belonging to better paying DRGs, and to "pass on" patients with conditions that are not going to pay well. For example, an elderly patient with a hernia is likely to require longer periods of hospitalisation: yet the hospital which treats that patient will receive only as much as it receives to treat a younger patient.

Both HMOs and DRGs have the potential to increase the efficient delivery of services. However, they have little to say on the equity of the services. A famous (and recent) attempt to deal with this problem took place in the state of Oregon. In Oregon it was proposed to list medical procedures in order of priority, so that all procedures above the cut off point would be funded by Medicaid and those below would not. This listing and prioritising was to be determined by the community, and to this end community meetings were held throughout the state.

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The wisdom of cases and the logic of principles

Gerald P. Gleeson

The "principle of double effect" is one of the more famous principles used to resolve difficult moral cases. Its application in medical decision making is evident in such cases as the removal of a woman's cancerous uterus even when she is carrying a child: the death of the child is said to be the justifiable secondary (or "side"-) effect of an action whose primary effect is to save a woman's life from cancer. Of course, the prospect of doing something that will lead to an unborn child's death ought to be daunting, but it is evident that in the tragic circumstances of a cancer which threatens the life of both mother and child, the "prudentially" wise course of action is to try to save at least the mother's life. The concept of one's action (removing the uterus) having a "double effect" or a "side effect" helps to articulate the soundness of the moral wisdom embodied in this course of action.

However, this principle is now so well known that its proper use in moral decision making is sometimes misunderstood in one of two ways. Should one suppose, first, that the role of the principle is "to justify" a course of action? Secondly, should one suppose that a course of action which does not meet the conditions of the principle cannot be morally justified at all?

These misunderstandings are explored by moral theologian James F. Keenan SJ in his important study: "**The Function of the Principle of Double Effect**".[1] Keenan notes that the principle and its four conditions can be taken to function in two quite different ways which, following Albert Jonsen and Stephen Toulmin, he calls the "taxonomic" and the "geometric".[2] He argues that the taxonomic use is the correct one.

Solving moral problems

The "geometric" use of moral principles likens moral decision making to solving geometry problems: principles and rules set out the conditions which a case must satisfy in order for a decision to be justified. Only if the various conditions are met does the principle apply, and if it does apply, it is the principle which justifies the course of action which it authorises.

The conditions required for such an application of the principle of double effect are (i) that one's course of action in itself be morally good or neutral; (ii) that the bad side-effect, though foreseen, be not intended; (iii) that the bad effect not be the means to the good effect; and (iv) that there is a proportionate reason for permitting the bad effect to occur.

It is clear how these conditions are satisfied in the case of removing a cancerous uterus from a pregnant woman. Note in particular that the immediate object of the surgeon's action (removal of a diseased organ) is good, and that the bad effect (death of the child) is not the means to saving the woman's life.

But what is the relationship between the justification of a course of action and the satisfaction of these conditions? The "geometric" use of the principle suggests that the doctor's action in removing a cancerous uterus is justified only because the conditions have been met. On the "geometric" view, if the conditions were not met - if, for example in the case of an ectopic pregnancy, a doctor directly removed the fetus rather than a woman's "diseased" fallopian tube, the action would not

be justified (because direct removal of the fetus amounts to abortion, thus contravening the first condition).

The authority of particular cases

Keenan argues that this "geometric" use of the principle is misguided, as are its implications for the case of ectopic pregnancy (of which more below). A doctor who removes a cancerous uterus from a pregnant woman is not justified because the conditions of the principle of double effect have been satisfied. He is justified simply because his course of action in the circumstances is certainly the right one. Keenan speaks of this prudential certitude as being "internal" to the particular case. The case provides a "benchmark" or "paradigm" of practically wise conduct in difficult circumstances. No prudent person could possibly judge otherwise. Reference to the conditions of the principle of double effect merely articulates the kind of prudential reasoning which is inherent in this correct course of action.

Contrary to the implications of a "geometric" view of moral principles, it is the wisdom embodied in particular decisions and particular benchmark cases which is paramount. Principles like the principle of double effect are "taxonomic": they help to classify various relevant similarities between cases. The principle of double effect manifests the similarity between the case of the cancerous uterus and a classic paradigm case considered by the moralists of old: that of a woman who flees from a charging bull, even as her flight prompts a spontaneous abortion (a case presented by Peter of Navarre who died in 1594). This woman's action was correct - prudentially wise - before ever the conditions of the principle of double effect were articulated by John of St Thomas (1589-1644).

The correctness or practical wisdom of one's course of action must always be inherent in the prudential judgment made in the particular case. So the function of the principle of double effect can only be "taxonomic", confirming "externally" the practical wisdom already implicit in moral decisions, and exhibiting the relevant similarities between cases: for example, between the case of removing a cancerous uterus, and the use of pain-killers which may hasten death, and the bombing of military targets which may lead to civilian casualties, and between those cases and the use of force in self-defence which may lead to the death of one's assailant, and so on. Sound principles depend on sound cases, not vice versa. Sound principles are "perspicuous descriptive summaries of good judgments".[3] Moreover, when faced with new situations calling for moral decision, the principle of double effect like other moral principles may well alert us to similarities with other cases already resolved with certainty and thereby help us identify the wise course to be followed.

But, given this subordinate function of the principle of double effect, when a proposed course of action in a new case does not fit the principle of double effect, it does not follow that it cannot be justified at all. First, the principle of double effect's function is not in any case to provide justifications, and secondly the justification, if it exists, may need to be articulated in terms of some other "principle".

Ectopic pregnancies

Consider again the case of ectopic pregnancy. The "geometric" application of the principle of double effect has led to the conclusion that surgeons must wait till the ectopic pregnancy causes a woman's fallopian tube to be damaged, at which point it may be removed, with the "side effect" of the child's death. In order to fit the ("external") conditions of the principle of double effect , the surgeon's "action" must be that of removing a diseased fallopian tube (in order to meet the first condition).

However, this approach occasions additional harm to a woman's reproductive tract. When the application of a principle that it is supposed to articulate practical wisdom leads to more harm than is necessary, then, as Keenan observes, moral reasoning has "gone amuck"!

Moreover, once we acknowledge the taxonomic use of the principle of double effect to highlight the similarities between cases, we see that the case of ectopic pregnancy is not like that of the cancerous uterus, or the use of pain

killers in terminal illness, or any of the other paradigm cases of "double effect". In the case of a cancerous uterus, the removal and death of the child is in no way the objective of one's action; it is truly a side-effect, not a means to saving a woman's life. But in the case of an ectopic pregnancy, removal of the fetus is crucial; it is not a side-effect, but the object of surgery, for it is precisely the fact that the fetus is growing in the wrong place which threatens the mother's life.

If someone thinks the principle of double effect must be used in a geometric way to justify cases, one will be led to modify and re-describe one's action in an attempt to meet the first condition - so that one's action is no longer morally wrong in itself. Thus, it is supposed that by waiting till the fallopian tube is damaged so that it may be excised, one is not thereby undertaking a direct abortion. But, as Keenan says, this approach merely "obfuscates what one is doing". Excision of the tube in this case (even when diseased) amounts to direct abortion since the removal of the fetus is one's overriding goal, and is the means to saving the mother's life.

Of course ending an ectopic pregnancy which threatens a mother's life is morally right. But it is not right because it can be made to fit the principle of double effect; and it cannot be made to fit that principle because it is crucially unlike the benchmark cases which the principle articulates. So:

> *"To confirm that ending an ectopic pregnancy is morally right, we can look for congruency with other internally-certain cases that belong to a rubric other than double effect".*[4]

Keenan suggests that we reconsider the analogy with cases involving a blameless, but unjust aggressor: ending an ectopic pregnancy would be like acting in self-defence. Of course the language of "aggression" is not entirely happy in the case of mother and child (and indeed this analogy was rejected by the Vatican's Holy Office in 1884). Keenan notes that

> *"Perhaps the question of saving a pregnant woman's life is unique enough to deserve its own constellation of cases"* (p. 315).

But which ever principles or analogies are employed, their function will simply be to confirm by comparison with like cases that one's action is ethically sound, prudential or practically wise.

Lessons to be drawn

What lessons are to be drawn from Keenan's study? First, sound moral judgments ("prudential" or practically wise judgments) in particular cases are the key to moral reasoning. "Principles" such as the principle of double effect are the distillation of moral wisdom: they identify the similarities in rationale between different cases.

Secondly, whether or not a new case can be fitted under existing principles provides some insight into the prudentially wise course of action. A course of action which meets the conditions of the principle of double effect is likely to be justified in its own right; a course of action which cannot be subsumed under the principle should give pause to thought as to whether it would be justified. But in either situation, the prudential solution is inherent in the case not derived from an external principle.

Thirdly, a course of action which cannot be subsumed under the principle of double effect (e.g. removal of an ectopic pregnancy) may nonetheless be justified, with confirmation of its justification coming from analogies with relevantly like cases (e.g. self-defence against a blameless aggressor).

Fourthly, the prudential judgment in the ectopic pregnancy case has implications for the discussion of "intrinsic evil" - that classification of kinds of action as wrong in themselves and so never able to be rightly chosen as ends or means to ends. At first sight, there seems here to be a case in which, tragically, one must do evil in order to avoid greater evils. This raises the difficult question whether intrinsic evil may sometimes be justified, and/or whether we need to be open to a refinement in our understanding of what counts as an intrinsic evil and of what it is to do evil. From the moral viewpoint, is removal of a fetus in the case of ectopic pregnancy not to be equated with the intrinsic

evil of killing a fetus? If it is not, then there will be no violation of the principle that one ought not do evil that good may come. I hope to explore these questions further in a discussion of the new Papal encyclical on moral issues which upholds the traditional conviction that evil may not be chosen as a means to a good end.

It is easy to see how the prudential wisdom embodied in the treatment of an ectopic pregnancy, might be taken (and abused) as a precedent for "doing the lesser evil" in other cases. But whether those other cases are truly like the case of the ectopic pregnancy remains to be shown. The critical "taxonomic" task will be to articulate more clearly the basis of the prudential judgment in this case, so that in confrontation with other cases the practically wise course of action may be discerned.

References

[1] James F. Keenan, "The Function of the Principle of Double Effect", *Theological Studies*, 54 (1993): 294-315.

[2] Albert Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning*, Berkeley: Univ. of California, 1988.

[3] Keenan, *op. cit.*, p. 300, quoting Martha Nussbaum.

[4] Keenan, *op. cit.*, p. 314.

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Health Care Resources: a history of the debate

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The Oregon project aroused much controversy, not the least of which was that it would effectively limit treatment available to the poor (who are the recipients of Medicaid), whilst those with private insurance would continue to receive a full range of services. Like DRGs and HMOs it was seen as being efficient at the micro-level. But the real problems are at the macro-allocation level.

Summary

There are problems in resource allocation which we are going to have to face at societal and institutional levels as well as at the level of individual health professionals dealing with their patients. In this paper, the experience and suggested solutions of other nations, especially the United States, have been outlined.

In the next paper in this series, Australian responses to these problems will be examined, as a prelude to a deeper examination of the ethical issues involved.

References

[1] J. W. Ross, C. Bayley, V. Michel and D. Pugh, *Handbook for Hospital Ethics Committees*, American Hospital Publishing, Inc., 1986, p. 66.

[2] Larry R. Churchill, *Rationing Health Care in America: Perceptions and Principles of Justice* ,Indiana: University of Notre Dame Press, 1987, p. 122.

[3] Churchill, *op. cit.*, p. 123.

[4] Australian Institute of Health and Welfare, *Australia's Health 1992*, Australian Government Publishing Service, Canberra. The graph is based on table S51, p. 347. The eight nations are Australia, Canada, France, West Germany, Japan, New Zealand, Sweden, and the United Kingdom. The United States is excluded from the eight nation mean.

[5] Reid, Elizabeth, *AIDS and Development*, Australian Council for Overseas Aid, 1988.

[6] Australian Institute of Health and Welfare, *op. cit.*, table S45, p. 341.

Communicative Ethics

A Review by John Quilter

Harry Moody's new book, *Ethics in an Aging Society*[1] emerges from a growing interest within Bioethics in the ethics of care of the elderly. Moody discusses moral quandaries in the care of victims of Alzheimer's disease and other dementias, Battin's proposal that suicide because of elderliness be held to be rational, the long-term care of the old in nursing homes and resource allocation given the greying of the population. On all these issues, Moody offers valuable insights, interesting suggestions and advances the discussion in what I take to be responsible ways. Of particular value is the set of distinctions he introduces to clarify a better framework for the discussion of age-based resource allocation raised by authors such as Daniels[2] and Callahan[3].

Moody's book, however, is not just a discussion of problems. In it, he also advocates a particular approach to these issues. In this review, I would like to take a little time to discuss his approach.

Moody calls his approach to the ethics of caring for the elderly "communicative ethics". He thereby connects his ideas to the work of the philosopher, Juergen Habermas, who invented the term[4]. Moody refers to Habermas with approval and, I take it, would like to be seen as continuing the lines of enquiry Habermas takes himself to have begun. Moody also sympathises with the contemporary trend of virtue ethics. Interestingly, Moody does not see communicative ethics as a competitor to virtue ethics but as a necessary complement to it. Virtue ethics is insufficient, he argues, to advance the debate concerning the care of the elderly. We need a communicative ethics to do that.

Communicative Ethics

What does this mean? To understand what Moody's advocacy of communicative ethics, it is helpful to pause over Moody's argument for his approach.

Moody aligns himself with the "liberal tradition". Though there is some confusion about the precise meaning of this term, for our purposes, Moody is a liberal in that he holds individual autonomy to be a central value and that public intervention into the social and economic spheres is justified and necessary for the sake of social justice. However, he is critical of the main philosophical tradition which has set out to provide intellectual foundations for such moral, political and social commitments in terms of "liberal principles". He argues, quite convincingly, that what usually goes by the name "respect for personal autonomy" in Bioethics, if applied to the care of the elderly, will in fact end up undermining such hopes for personal autonomy as the elderly have in their typical predicament, especially in the nursing home setting. And he also argues that attempts by philosophical liberals such as Rawls[5], Daniels and others to defend government measures to ensure the care of the elderly in terms of liberal principles are simply idle and, therefore, without the intellectual strength to support the necessary politico-moral position.

Given that traditional philosophical liberal principles are not enough and can even be counterproductive, where do we go? The greatest need, Moody argues, even in the most perfect of human social systems, is for individual virtue on the part of professionals in the system, its clients, bureaucrats and its leadership. Principles require wisdom for their application and virtue for their implementation. However, more than individual virtue is required.

The issues facing us in the care of the elderly require the reform of social institutions to be able more appropriately to serve the autonomy of the old and to ensure that the sharing between the generations and age cohorts of the benefits and burdens of living in society is equitable. But such matters are social questions. They therefore

require us to listen to each other carefully and generously, to give and take, negotiate and renegotiate. Vested interests must be suspended or their selfish influence on us not allowed to deafen us to others' claims on us. And so on. Moody argues that we need an ethical approach which carves out a *communicative* space to allow the necessary negotiations within relationships of solidarity to take place. That is, virtue needs to be complemented by a communicative ethics.

Now, clearly, since these issues in the care of the elderly have social, economic and political dimensions, an ethically adequate response to them requires consideration of political or social ethical matters. Further, we can only expect to achieve decent negotiations between parties involved in the resolution of these issues where their approach to the process is not primarily competitive but cooperative. This is the burden of the book's last chapter, an extended meditation on Max Weber's essay "Politics as a Vocation". If it is points like this that communicative ethics makes, then I suppose we all can claim to be "communicative ethicists". The problem I have with Moody's argument, however, is that such observations do not need an appeal to Habermas to make sense or to find justification. And further, the appeal to Habermas may be misleading and, at worst, even an impediment to an adequate response. Let me explain in connection with resource allocation.

The parents of the baby boomer age cohort belonged to the era of Australia, the Lucky Country. Their children belong to Australia, the Changing Country, with an unsure future and large unemployment. Many are worried that not only will they not be able to leave to their children a better life but they will leave them a significantly harder one than they had.

It is a plausible constraint on any adequate work on resource allocation that its objective be inter-generational equity. Inter-generational equity concerns the fairness of the system or social structures whereby persons, as belonging to identifiable age groups, are cared for. For example, it is a more just social arrangement to have the capable adults working to look after the children and elderly in the society than the other way around. Likewise, a society would be objectionable which provided luxurious care for children but made no effort to look after older people once they could not work full time. The urgent resource allocation question confronting us as our population gets older concerns what is fairness when it comes to looking after more and more elderly who cannot generate wealth, given that we must also ensure that our young people are properly cared for and that the economy generates adequate wealth. For example, every superannuant in Australia who spends his lump sum on a world trip and then goes on the pension represents that much greater burden on the public purse and puts greater strain on our ability to provide our children with high quality, reliably accessible education. We must ask whether a system which permits this sort of behaviour is fair.

Now, one of the special problems which emerges when one starts to think through some of these problems is that, even when one has a workable *system* in place for the just provision of care to all age groups in society, particular age cohorts will not necessarily end up faring as well as others. For example, people who were the parents of the baby boomers after World War II found it relatively easy to buy their own homes and many can reliably look forward to a world trip upon cashing the superannuation and then going on a reasonable pension. It is arguable that their children will not have it so easy. Many who bought houses in the 1980s are locked into exorbitant home loan interest rates and cannot be sure of the security of their superannuation or, failing that, of such generous pensions as their parents receive. Many now cannot buy any form of assets where their parents at a comparable age were well on the way to owning their own home. The parents of the baby boomer age cohort belonged to the era of Australia, the Lucky Country. Their children belong to Australia the Changing Country with an unsure future and large unemployment. Many are worried that not only will they not be able to leave to their children a better life but they will leave a significantly harder one than they had.

Now, what matters for our purposes here is not the exact truth of the example. What matters

is that, since such a scenario might be true, there is a contrast between (a) having a *system* which, in the abstract, fairly distributes the benefits and burdens of living in society across the age groups and (b) the details of the way we actually try to approximate it in the relationships between age cohorts as time rolls by. For instance, it may be reasonable in the abstract to expect working age people to be taxed to support the pensions of their parents once they retire. However, given the economic differences between the seventies and eighties on one hand and the more austere nineties and an unsure future on the other, might we not control the use of superannuation by those who retire now so that they may not spend it on that world trip so that money they would use up in pensions is left available for later use by their children when *they* reach retiring age? The issues of inter-generational equity are not simply matters of system design but also must involve communication and give and take between the particular age cohorts of parents and their children.

My point in criticism of Moody is that this kind of point can be made quite strongly, if we are honest, without the apparatus of a "communicative ethics". Progress on the resolution of these problems does require good will and a serious intention to listen to the needs and legitimate concerns of each other across generational and age cohort differences. Moreover, one should *expect* that this will be an inextricably political process. However, it is not clear that there is any reason to represent this need for communication as "a communicative ethics".

However, it could be worse than this if Habermas is genuinely Moody's inspiration. For Habermas in one way or another takes the necessary aim of a communicative ethical conception of political negotiation to be consensus. Certainly, consensus would be best. However, here, as often in political matters, holding out for the best can be the enemy of the good. If we must have consensus, the basis of agreement may be so thin as to be useless. We may have to go with partial solutions and piecemeal agreement between a few of the participants to the debate at a time. That would be good. Hoping for something better, we might lose hold of what we can achieve in the real world of vested interests, disagreeing perceptions and odd historical contingencies.

The odd thing about this point is that in connection with his insightful discussion of long-term care of the elderly, he makes the same point about the limits of the importance of consensus. I therefore have an overriding caveat for the potential reader concerning Moody's advocacy of communicative ethics: much that is insightful and illuminating in his discussion can be had without the Habermasian super-structure.

This said, however, it remains that this is a book which repays study. It offers a thoughtful discussion of some very difficult and painful issues. Some might be worried that his attention to the details and political biases of the debates in the United States will limit its value for the Australian reader. This is not so. Much of what he has to say concerning dementia in the elderly and long-term care in the nursing home carries over to the Australian situation and the proposals he has for the remedy of the US system are a fertile soil for our reflection. In particular, Moody makes some valuable distinctions to help clarify the shape of the problems of resource allocation in an aging population. Besides the fact that in the production of the book too may typographical errors have been allowed to get through, I recommend it to anyone interested in ethical questions in the care of the elderly.

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NOTEBOOK

Post-Graduate Courses in the Ethics of Health Care Australian Catholic University

There is today widespread interest in the ethical aspects of health care. Justice in the allocation of resources, consent to treatment, what patients who express a wish to die really want, withdrawing or withholding of life-sustaining treatment, transplantation of organs, IVF, the role of the law in the regulation of health practices: these are just some of the issues which every educated person and in particular professional people working in health care ought to have thought about.

The two new post-graduate courses in the ethics of health care which are to be offered for the first time at Australian Catholic University in 1994 ought therefore to attract widespread interest. These courses - a Graduate Certificate which will begin in the first half of the year, and a Master of Arts which will begin in the second half of the year - are designed for people working in health care: clinicians, administrators, allied professionals and members of institutional ethics committees. However, they will also be of interest to anyone who has found himself or herself reflecting on some of these ethical issues. Both courses have core units in moral philosophy and theology and specialized units in the ethics of health care.

Initially, both courses will be offered at the Mackillop Campus of Australian Catholic University at North Sydney (though the specialized units in the Master of Arts will be offered at the Darlinghurst Campus of St Vincent's Hospital). Units will be of semester length and will require weekly attendance. The courses will be fee-paying (and therefore will not attract Higher Education Contribution Scheme (HECS) costs).

Graduate Certificate in Applied Ethics (Health Care)

This is a basic course in applied ethics for professional people who work in health care. Applicants are required to hold a degree or equivalent professional qualification in a relevant field and to have had relevant professional experience. The course consists of four units: two core units: *Reason and Ethics* and *Religion and Ethics* and two specialised units: *Principles of Bioethics* and *Health Care and the Law.*

Master of Arts in Applied Ethics (Health Care)

This is an advanced course in applied ethics for those who have leadership roles in medicine, nursing, social work and health care administration. It provides an opportunity for extended research in some aspect of the ethics of health care. The course consists of eight units: four core units: *Ethical Decision Making Parts 1 & 2, Religion and Ethics in a Pluralist Society* and *Research Methods and Critical Thinking* and four specialised units.

Applications for the Graduate Certificate for 1994 close 10th December 1993 and for the MA Course, 25th March, 1994. Application forms may be obtained from: The Admissions Officer, Australian Catholic University, 179 Albert Road, Strathfield, NSW, 2135. Phone (02) 739 2218. For further information contact the School of Religion and Philosophy, Phone (02) 739 2252.

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