Ethics dialogues across professional groups may bring us closer to good decisions on priorities. But it is far from certain that they will take us all the way.

Priorities in the borderlands

A strident debate on priorities has raged in Norway over this past year. Its main emphasis has been on costly cancer drugs for life-prolonging treatment. The Directorate of Health has called for a debate on the setting of priorities in Norwegian health care (1). The question is, however, whether we have the debate that we wanted, since the debate on priorities came to focus on setting price tags on human life and on what costs patients really should be allowed to inflict on society.

Even though costs serve as the backdrop to all priorities, the benefits of treatment remain a key element of all such debates. Perhaps the principles of equitable priorities can be identified more easily if the effects of treatment take centre stage in the argumentation? This was the claim put forward by Alena Byux and collaborators, who have proposed to set priorities on the basis of a minimum threshold of clinical effectiveness (2). If we envisage that all patients in a public healthcare system must abstain from treatment that has only a «minimal effect», the healthcare system stands to save vast sums. And, since «the sacrifice» that each individual must bear because of this type of prioritisation in any case will be minimal, people in general will be more ready to accept such priorities. Nobody will need to forego considerable treatment benefits, but everybody must be willing to forego minimal benefits. According to the authors, this approach might find favour among the population, simply because it is fairer than the alternatives.

In this issue of the journal, Ingrid Miljeteig and collaborators discuss the topic of priorities (3). Unlike last year's debate, however, they do not refer to cancer patients. Instead, they describe a far more vulnerable group of patients, who have no strong patient organisations or the media to back them up; they refer to drug addicts. The question asked by the article's authors is whether a second valve replacement surgery should be offered to patients who are addicted to drugs. With regard to cancer, the burden of proof rested on those who wanted to deny the patients life-prolonging treatment. In this context, «the burden of proof» may appear to rest on those who want to offer life-saving and life-prolonging treatment to drug addicts. This sets the debate on priorities in perspective.

What are the benefits of a second valve replacement surgery? Can the costs be defended? In decisions on priorities, how should we apply the principle that says that everybody is responsible for their own health? And does it make sense to prolong the life of a drug addict if the addiction is likely to persist? These questions are all highly relevant for the decision on whether treatment should be offered or withheld.

These questions are of a professional as well as an ethical nature. Solid medical documentation is a necessary, but not a sufficient condition to provide an answer. Thereby, the first challenge will consist in determining who will be best suited to provide an answer to such issues of prioritisation. The methodical approach in this article is to let seven people from widely differing, but relevant professional backgrounds discuss the matter in light of a systematic analytical model. The approach is well known – the same mindset forms the basis for the committees of clinical ethics which are found in all Norwegian health enterprises. The idea is partly that questions of medical ethics are best addressed through open dialogue and discussion, and partly that this dialogue and discussion will be best if undertaken in a systematic manner that can ensure inclusion of all relevant considerations.

The majority of the authors concluded that as a main rule, a second valve replacement surgery should be offered in case of recurrent infectious endocarditis in drug abusers. The benefits of the treatment exceed the minimum effect by far. This points towards provision of treatment. But what about the costs? Although high, they are no higher than what we have been willing to spend on certain particularly costly drugs for cancer patients. Nor should the principle of responsibility for our own health be invoked against the drug-addicted patient. We are thus referring to identical cases, and such identical cases should be subject to identical treatment (3).

Otherwise, the entire group agrees that these types of decisions on priorities ought to be taken at a general level and should not be left to the individual clinician. Ethics dialogues across professional groups and committees of clinical ethics may represent good examples of such general levels. National guidelines are at an even more general level, and have the advantage that patients in different parts of the county will be treated according to the same ethical assessments, which seems to safeguard considerations of fairness.

The debates on prioritisation in Norwegian health care are here to stay. There can clearly be no final answer to what constitutes a reasonable relationship between the effects of a course of treatment and its costs, irrespective of whether one discusses cancer medicines or heart valves for drug addicts. The inter-professional dialogue on priorities is therefore important, but the question is whether it is sufficient. In this dialogue, some will invariably emphasise effects, while others will focus on costs. The expert commission for cancer drugs reversed its views on ipilimumab in the face of new information on long-term survival rates. The effects were the decisive issue, and the commission recommended both ipilimumab and arbiraterone. The Directorate of Health, however, went thumbs down by pointing out that the commission had failed to take sufficient account of the costs. Finally, Minister of Health Jonas Gahr Støre went thumbs up for ipilimumab. Fairly reasonable people thus failed to agree on a reasonable relationship between costs and effects.

Dagens Medisin concluded that tactical considerations have been involved in the process and that the handling of the matter weakens the understanding and legitimacy of difficult prioritisation in the eyes of the general public (4). But what if the problem runs even deeper? What if it has become politically impossible to say no to forms of treatment that can be claimed to provide a considerable health advantage to individual patients – irrespective of costs? What if it has become possible to say no only to forms of treatment that we know for certain will have barely minimal effects for the individual patient? What if this is not about political manoeuvring, but about theories of justice? If yes, we are currently attempting to prioritise on the basis of the wrong criteria in our efforts to strike the right balance between costs and effects. This *could* be a lesson learned from the process involving the costly cancer drugs. If we prioritise based on the wrong criteria, perhaps even good dialogues on ethics will be insufficient to come to an agreement?

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