

SPECIAL ARTICLE

Discussion document on the ethical aspects of the allocation of health care resources

World Medical Association

This document has been approved by the Council of the World Medical Association (WMA) for publication and distribution to the national member associations. The document is not an expression of WMA policy, but is simply intended to stimulate reflection and discussion about the issues associated with allocation of health care resources. The Council welcomes comments on this document, which it will take into account in its ongoing work on this subject.

1. Purpose and scope

1.1. The World Medical Association is dedicated to serving humanity by endeavouring to achieve the highest international standards in medical education, medical science, medical art and medical ethics, and health care for all peoples of the world. In pursuit of this goal it has developed and promulgated numerous resolutions, statements and declarations which represent a general consensus among national medical associations (NMAs) on ethical issues in medicine and health.

1.2. Some issues in medical ethics do not lend themselves to a ready consensus among physicians. There are several reasons for this. Certain issues (e.g. the problems arising from the human genome project) are novel and there is insufficient experience and ethical reflection to arrive at a consensus. Other issues (e.g. abortion and experimentation on embryos) are clearly defined but elicit completely different ethical evaluations depending on one's religious or philosophical value system. Then there are issues that evoke disagreement based on political, social and economic factors which vary from one nation to another. Allocation of resources is an example of this type of issue.

1.3. The WMA has studied the issue of resource allocation for several years. The Scientific Session at the 1993 WMA General Assembly featured a thorough discussion of this topic. The session served to identify many facets of the problem and brought together differing perspectives of physicians from countries with a variety of health care systems.¹ Following this session, a working group of the WMA Medical Ethics Committee produced a 'Proposed WMA Statement on Allocation of Health Care

Resources' which was discussed by the Committee in April 1994. It was then distributed to all WMA member associations along with a questionnaire designed to elicit the views of NMAs on the document as a whole and on each part of it. A half-day was set aside before the 1994 WMA annual meeting for the working group to analyse the results of this survey and to prepare a final version of its proposed statement for consideration by the WMA Medical Ethics Committee.

1.4. In the working group's discussions, disagreements about some of the key issues in resource allocation resurfaced and consensus could not be reached on a statement. It was agreed that the goal of producing a WMA statement on this topic should be set aside for the time being. Instead, the working group would produce a background paper of an educational nature that would seek to illuminate the issues involved, together with a set of principles for the guidance of NMAs and, through them, their individual members. This paper is the result of the working group's deliberations.

2. Definitions

2.1. Some of the diversity of views on the ethics of resource allocation is the result of different understandings of the key terms in the debate. For the purposes of this document, the working group has adopted the following definitions:

(i) **allocation**: an act of distribution of resources, tasks, etc. which does not necessarily imply any shortage of the things to be distributed; (ii) **prioritisation**: the establishment of a rank order among goods (values, tasks, outcomes, etc.), usually when not all goods can be obtained at once; (iii) **rationing**: this term has two distinct meanings: distribution of limited resources according to specific criteria, where the needs of recipients are fairly uniform and predictable, e.g. rationing of foodstuffs; and deliberately restricting access to needed and potentially beneficial resources on the grounds of cost alone. Those who prefer the first meaning do not consider rationing as such to be either good or bad, as it implies a just and equitable distribution apart from the ability to pay; those who prefer the second consider it bad, at least if it is implemented by physicians.

In view of the ambiguity and complexity of the meaning of the word 'rationing', and the fact that individual health care needs are not uniform, the word is not used elsewhere in this paper.

3. Dimensions of the issue

3.1. Decisions about the allocation of resources for health care take place at three levels: macro (national/federal and/or state/provincial), meso (regional and institutional) and micro (individual patient).

3.2. At the macro-level, decisions are made on the following issues: (i) how much funding should be designated for health care compared with other public goods (education, housing, roads, etc.); (ii) how should the health budget be apportioned to: capital and operating expenses

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of hospitals, clinics, rehabilitation and chronic care facilities; new equipment and services; remuneration for physicians, nurses, and other health care workers; drugs; research; etc.; which of these expenses are to be met from public funds and which are to be charged to individual patients. The principal decision-makers at the macro-level are governments, insurance companies or other major funders of health care.

3.3. At the meso-level, regional boards, insurance companies and individual facilities are faced with many allocation decisions, such as which services to provide, which categories of patients to treat, what equipment and drugs to purchase. The principal decision-makers at this level vary depending on the country, but could be physicians or other health professionals, hospital administrators and members of elected or appointed boards.

3.4. At the micro-level, physicians and other health professionals have to deal with many allocation decisions, for example, which diagnostic or therapeutic procedures to use; how much time to spend with a patient when others are waiting; whether to order tests that are not likely to influence the treatment plan greatly; whether to discharge a patient from hospital early because the bed is needed by other patients. Decision-making at this level is the shared responsibility of physician and patient, although the relative degree of authority varies greatly from nation to nation and from physician to physician.

4. Diversity of national medical systems and resources

4.1. In all countries — rich and poor — resources are finite in the sense that no society can afford to meet all demands. Therefore, a certain degree of prioritisation is necessary.

4.2. The process a nation uses to determine health care priorities is related to the type of health care system the nation has adopted. In some countries the government or the legislature plays a decisive role in allocating funds and in specifying how those funds should or should not be spent. Access by physicians and their patients to health care services may be limited by government-imposed restrictions. In other countries market forces play an important role in allocating resources, although government and non-governmental organisations are also involved. Access by physicians and their patients to health care services may be limited by restrictions imposed by private sector organisations.

4.3. Whichever way priorities are determined, the availability of health care services will vary greatly from country to country and from time to time depending on the stage of development of the country and the amount of total resources at its disposal.

5. Ethical considerations

5.1. Allocation of health care resources is an ethical issue because it affects the well-being and autonomy of patients, providers and societies/states and because it can be fair or unfair.

Well-being

5.2. A physician has a primary duty to do all that he/she can for the well-being of the individual patient.² Policies for allocating limited resources have the potential to limit the ability of physicians to fulfil this duty. Therefore it is in the interests of both patients and physicians to maximise the availability of resources for health care. However, patients and physicians should recognise the competing claims for public or private funds of other social goods, such as education and social security.

5.3. The well-being of a society or nation requires that a significant portion of its total resources be allocated to health care. Expenditures in this area are investments in human resources, leading to diminished individual suffering and opportunities for people to return to productive work or to live in their own homes or at less expensive levels of care. Expenditures on health care services therefore tend to have a positive effect in reducing other social costs.

5.4. The well-being of physicians is often directly affected by allocation decisions of government and financiers of health care, especially those that deal with physician supply, remuneration and working conditions. Although the well-being of their patients is the first consideration of physicians, they have a right to expect fair treatment from government and employers in matters that affect them directly.

Autonomy

5.5. Patients have the right to make decisions individually about their health care,³ and to be involved collectively in the public debate on the overall use of health care resources. If, for whatever reason, the patient cannot obtain the necessary care, they have the right to be fully informed about the reasons for that situation. This should be in addition to all the customary information on the risks and benefits of and alternatives to any medical procedure.

5.6. The medical profession has a responsibility to use health care resources optimally; this includes using cost-effective diagnostic and therapeutic methods, which also include the elaboration of applicable and realistic quality criteria and practice parameters.

5.7. Autonomy is also attributable to a society or state, which can decide to limit resources available for certain collective goods, such as health care. In order to exercise this prerogative in the most beneficial way, society or government leaders need to know how citizens can receive needed health care in the most cost-effective and efficient ways. There is a need for well-balanced and sound decisions in these matters, which must be made in consultation with physicians, who have a responsibility to participate in those discussions. Governments should not, however, preclude individuals from access to health care services through insurance plans or otherwise. On the other hand, the medical profession has an obligation to ensure that this right does not unfairly interfere with other individuals' access to health care.

Fairness

5.8. Allocation decisions and policies should be fair. If priorities concerning patients have to be made, they should be based only on accepted ethical criteria relating to medical need. These criteria include likelihood of benefit,

urgency of need, change in quality of life, and duration of benefit. Non-medical criteria, such as ability to pay, supposed value to society, perceived obstacles to treatment, patient contribution to illness, or past use of resources, should not be considered. All patients should have equal access to care, without discrimination on the basis of age, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or disease or disability, except insofar as they have an impact on the medical prognosis.

5.9. There are differences between and within nations with regard to the criteria for a fair health care system.

Some argue that fairness requires full equality of access to health care resources for all citizens, regardless of their economic or social status. They oppose a system which provides a basic level of health care to the poor and a higher level to those who can afford it, or a system where those with money can circumvent the procedures for prioritisation.

Some consider a system to be fair if it does not interfere with the control of individuals over their own resources. If they wish to purchase a higher level of health care than is provided to others, it would be unfair to deny them this freedom.

Some prefer to consider fairness an attribute of procedures rather than outcomes. As long as the process for making allocation decisions is fair, i.e. it is open to public scrutiny, involves all interested parties and provides reasons for the decisions, then the decisions themselves are also fair, whatever they may be.

6. Roles of individual physicians

6.1. Discussions within the WMA at the 1993 Scientific Session and at other meetings have made it clear that there is considerable disagreement among physicians about their role in allocating health care resources.

Some feel that there is no such role: the treating physician must remain a patient advocate and should therefore not participate in allocation decisions.⁴

Some distinguish between their own resources and those of society: they do not deny the need to allocate resources such as their office time, their access to operating theatres, etc., among their patients, but they refuse to limit their patients' access to publicly or privately funded health services, such as laboratory tests and specialist consultations, even if these are in short supply and other patients may need them more.

Some consider that they have a responsibility to other patients besides their own, so that it is not unethical to exercise a 'gatekeeping' role by restricting their patients' access to health care resources.

6.2. In balancing the roles of patient advocate and gatekeeper all physicians acknowledge their duty to uphold the legitimate interests of their patients.⁵ Furthermore, all physicians acknowledge the need for triage in extreme situations, such as disasters.⁶

6.3. Some physicians face an ethical conflict in that they play a role in formulating allocation policies at the institutional level which affect their own patients, among others. This conflict occurs in hospitals and other institutions where physicians hold administrative positions, or serve on

committees where policies are recommended or determined. In these situations physicians need to balance the ethical principle of fairness to all patients against their duty to seek the best treatment for their own patients.

6.4. Regardless of which views physicians hold on their role in allocating health care resources, they generally agree that resources should not be wasted. Physicians need to ensure that in providing the necessary care, they use existing resources effectively, efficiently and appropriately. Therefore, they must be aware of the cost of the tests and treatments they prescribe. Furthermore, elements of health economics should be part of continuing medical education.

6.5. Responsibility for the efficient use of resources rests on the full competence of physicians. To fulfil this responsibility, physicians must have the necessary autonomy, professional independence and authority.

7. Roles of NMAs

7.1. There is general agreement within the WMA that whenever an NMA deems the available health care resources to be inadequate, it should make this clearly known to the responsible decision-makers and the population, and take the necessary measures to convince them to allocate the additional resources needed for appropriate health care.

7.2. Decisions about the allocation of resources among various sectors of health care, (e.g. preventive v. curative care, primary v. secondary care) are the responsibility of governments or insurance companies, or the financiers of the system. However, they need to have the advice of the medical profession. NMAs need to supply these decision-makers with clear and accurate information in order to achieve health care systems where patients receive appropriate medical care in organisational forms which are cost-effective and best suited to the attainment of this objective.

7.3. In exercising their self-regulatory function, NMAs should include cost-containment activities, including those that relate to methods of delivery of medical care, access to hospital and surgery, and the appropriate use of technology. Over-utilisation of medical facilities should not be permitted to drive the cost of medical care upwards so that it will not be available to all who may need the particular care.⁷

7.4. The primary aim of medical practice should be to provide ethical and humane care of as high a calibre as possible. Physicians, institutions or organisations deviating from this aim by giving precedence to making a profit should be condemned. NMAs should draw public attention to any such cases, and initiate appropriate action against the perpetrator wherever possible.

7.5. NMAs should study and stimulate discussion among all concerned sectors of society about the implications of limiting health care resources and all other aspects of health resource allocation.

8. Role of the WMA

8.1 The primary role of the WMA is educational — to set forth the issues as clearly as possible in order that NMAs

and their physician members can reflect on their roles and responsibilities in this area and contribute to policies which are in the best interests of patients, providers and society. It is hoped that this will help to resolve the differences between physicians on this topic.

This document will be reviewed regularly and revised as times and thinking change.

NOTES

1. Field IT. Rationing in health care. *World Medical Journal* 1993; **39**: 61-66; Fuchs C. Ethical dimensions and dilemmas of rationing. *World Medical Journal* 1993; **39**: 75-78; Gillibrand M. Waiting lists. *World Medical Journal* 1994; **40**: 1-3; Mandell BB. Rationing of health care — the physician's perspective. *World Medical Journal* 1994; **40**: 3-9.
 2. *WMA Declaration of Geneva* (1994): 'The health of my patient will be my first consideration.'
 3. *WMA Declaration of Lisbon on the Rights of the Patient* (1981): 'The patient has the right to accept or to refuse treatment after receiving adequate information.'
 4. *WMA Declaration on Physician Independence and Professional Freedom* (1986): 'Within the context of their medical practice and the care of their patients, physicians should not be expected to administer governmental or social priorities in the allocation of scarce health resources. To do so would be to create a conflict of interest with the physician's obligation to his patients, and would effectively destroy the physician's professional independence, upon which the patient relies. 'While physicians must be conscious of the cost of medical treatment and actively participate in cost-containment efforts within medicine, it is the physician's primary obligation to represent the interests of the sick and injured against demands by society for cost-containment that would endanger patients' health and perhaps patients' life.'
 5. *WMA Statement on Patient Advocacy and Confidentiality* (1993).
 6. *WMA Statement on Medical Ethics in the Event of Disasters* (1994): 'From the ethical standpoint, the problem of triage and the attitude to be adopted towards victims "beyond emergency care" fits within the framework of the allocation of immediately available means in exceptional circumstances beyond human control. It is unethical for a physician to persist, at all costs, at maintaining the life of a patient beyond hope, thereby wasting to no avail scarce resources needed elsewhere. 'The physician must act according to his/her conscience considering the means available. He/she should attempt to set an order of priorities for treatment which will save the greatest number of serious cases that have a chance of recovery and restrict morbidity to a minimum, while accepting the limits imposed by the circumstances.'
 7. *WMA Declaration of Madrid on Professional Autonomy and Self-Regulation* (1987).
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