3. Ethical Considerations in Equitable Allocation and Distribution of Limited Health Care Resources

Introduction

The purpose of this report is to identify relevant conceptual and pragmatic considerations for the development of strategies for the equitable allocation and distribution of resources. In the following discussion we make two presumptions regarding limited health care resources.

We *presume* that the current allocation of resources in the national economy is relatively fixed between competing major federal funding categories such as education, health care, defense, and social services. This presumption rejects the facile solution that rationing of scarce health resources may be avoided by simply moving funding from one major category to another to increase total funding for health care.

We *presume* that wasteful practices occur in the allocation and distribution of health care resources, which may limit some beneficial services. We reject the claim that if waste in health care delivery was eradicated, resources would no longer need to be limited. Reducing waste is an ethical imperative. While waste in health care is being reduced, covert and widely divergent rationing strategies will occur. Therefore, explicit practices that fairly allocate and distribute health care resources are necessary, as well as practice guidelines and other means to control inefficient or wasteful practices.

Informed discussion of equitable allocation and prudent distribution of limited health care resources needs to acknowledge the contemporary societal factors that are promoting the larger discussion of health care reform within both VA and the private sector. Health care reform and the related issues of allocation and rationing have recently been given a higher societal priority for a number of reasons. These include, but are not limited to: limited access to care by millions of Americans; increasing health care expenditures; wide variation in utilization of health care services without appreciable differences in outcomes; use of expensive technologies and treatments with marginal benefits; fear of catastrophic personal consequences associated with treatment for illness; a culture that embraces seeking treatment for every ill; loss of insurance due to change of employment; loss of coverage due to heavy usage; inability to obtain coverage because of pre-existing illness; and limited insurance coverage for home, outpatient, psychiatric, and long-term care. These societal concerns may or may not always overlap with issues of equity or fairness. The determination of fairness in allocation and distribution requires critical analysis. Simple cost containment measures may not provide equitable solutions. Even if some consensus is achieved regarding what constitutes equitable or fair procedures, some individuals will continue to view the procedures as unfair because they still have health care needs that are unmet while other individuals are receiving health care resources for their needs.

Definitions

To facilitate our discussion of equitable allocation and distribution of limited health care resources, we offer definitions or clarifications of the following terms and concepts.

Equity

The principle underlying equity is impartiality or fairness. However, fairness may be interpreted in many ways depending on one's political and philosophical perspective. From a libertarian perspective, fairness would allow any individual who developed capital

worth through legitimate means to purchase whatever health care services he/she desired. An egalitarian would believe equal access to health care for those with equal needs to be a requirement of fairness. In our discussion, we assume more of a contractarian position in which equity would imply provision of whatever resources any rational person would desire if they were ignorant of their personal attributes and status in society. This form of distributive justice has been described by Rawls and is often demonstrated by developing rules behind "a veil of ignorance."

Allocation

Allocation occurs when monies or resources are distributed across competing venues. Health care represents one venue. Defense and education, for example, are two other venues with which health care competes.

Rationing

Rationing is a system of rules for limiting beneficial and scarce resources among those individuals who have a claim on those resources by limiting availability and/or utilization. Patient-centered rationing limits particular individuals or groups from access to selected treatments, e.g., elderly people from dialysis, terminally ill people from intensive care units, people with a history of alcohol abuse from liver transplantation. Resource-centered rationing limits access to certain resources, e.g., regionalization of MRI scanners to which individual medical centers may have shared or limited access.

Cost Containment

Cost containment is the limitation of health care spending, achieved through strategies to control the increasing share of health care expenditures in relation to the GNP or other sectors of the national economy.

Scarcity

Scarcity is the shortage of a good for which there is a dire need. Resources may be finite, but not scarce. Scarcity implies greater

demand than availability, while finitude refers only to the resources' availability and does not take into account the demand.

Basic vs. Non-basic Care

The definitions here may differ significantly from what is included in certain basic benefit plans. Also, comparisons of basic and non-basic care often presuppose theoretical and value-laden distinctions between levels of treatment that have not been stated and often lack community consensus. These reservations stated, we present basic care as preventive, curative, and rehabilitative treatment that has proven efficacy and compensates for deficiencies in the range of normal biological and social opportunities persons enjoy at each stage of life. In contrast, non-basic care either aims to improve conditions unrelated to normal opportunities, or it aims to correct or compensate for deficiencies in normal opportunities, but it is marginally effective or ineffective in doing so. Therefore, non-basic care is discretionary, often with questionable benefit, and is supererogatory. For example, a diagnostic test that does not change therapy, a life-sustaining treatment which merely prolongs the dying process, and some cosmetic surgery all qualify as non-basic care. By limiting the distribution of non-basic health care, resources may be conserved and may help to ensure access to at least a minimum level of basic health care for all veterans. The distinction is emphasized to prevent artificial inflation of the costs of basic care by including under this category care that would more appropriately be labeled non-basic.

Education for the Health Care Consumer about Limitations

The financing and structure of health care delivery strongly affects the process of care. Autonomy has been valued highly in our health care system, as have the physician-patient relationship and the role of the physician as the patient's advocate. But with increasing emphasis on cost containment and expanding access and availability of care to all, and the recognition that resources are limited, constraints may need to be placed on the patients' choices. The public must be educated about the need and justifications for limitations. Society will more likely

approve of limits when everyone is contributing equitably. Our society must be asked to re-evaluate its unrealistic emphasis on health services as the principal source of happiness or good health. Of particular concern are the misperceptions that veterans may have about the extent of health care benefits to which they are entitled. Consensus must be encouraged about care that is of such marginal utility that society can and must refuse to support it economically and morally. Medical care that merely prolongs the dying process should be discouraged for all age groups. The most desirable health care policy is one that mandates comprehensive benefits, meets the basic needs of most individuals, and is cost-effective.

Ethical Considerations in Allocation and Distribution

1. Limiting access to beneficial health care services should occur only when there are inadequate resources to meet the need. Resources include treatments, diagnostic tests, space capabilities, personnel, and finances.
2. If resources are saved as a result of rationing, the savings should serve to provide greater health care benefits to others.
3. Individuals with equal needs should have equal access to health care resources, and disparities in access due merely to geographic location should be minimized.
4. Patients' absolute power to dictate or demand a specific treatment must be tempered in the formulation of strategies for equitable allocation and distribution of health care resources. Respect for autonomy is exercised in the context of offering reasonable medical treatment.
5. The definitions and determinations of the following principal considerations should be developed, with representation from all interested and affected parties:
    - basic vs. non-basic health care,
    - medical benefits/burdens,
    - patient responsibilities, and
    - medical futility.

6. In reaching an allocation or distribution decision, management should actively consider other equally deserving and meritorious needs, including those not being forcefully advocated.
7. New and technologically innovative treatments are attractive to providers and consumers alike. These are often costly and have the potential to add significantly to health care expenditures without necessarily having greater effectiveness than treatment already available. Therefore, new technologies should be included in VHA's armamentarium only after they are shown to be more effective or more cost-beneficial than current therapies.
8. By the same token, currently used diagnostics or therapeutics shown by outcome studies not to be effective should be eliminated.
9. A clear and honest determination and reorganization of the several missions within each Veterans Integrated Service Network (VISN) is required.
10. Non-clinical criteria for patient care eligibility create ethical dilemmas that require thoughtful consideration.

Procedural Considerations in Allocation and Distribution

1. Equitable strategies for allocation and distribution of health care resources should be explicit, public, and accessible.
2. These strategies should be developed with representation from all interested and affected groups. This assures that assessments of benefits and costs are not limited to the views of a single group and a single time frame.
3. Strategies for rationing care that focus on patients' characteristics (patient-centered rationing) should be used only when resource-centered rationing strategies prove to be inadequate. Patient-centered rationing strategies should focus on the magnitude of patient-centered medical benefit and avoid social worth criteria (age, sex, race, education, social class, productivity). Queuing on the basis of relative medical benefit to an individual as a means of rationing health care is a morally justifiable and acceptable policy.

A queuing strategy for allocation should take into consideration possible inequities that will arise due to unfair (dis)advantages associated with physical or mental disability, education level, access to information about available treatments, sophistication in obtaining treatment, financial status, etc.

4. If all other criteria are equal, those individuals with equal need and anticipated benefit may be selected for treatment by use of a lottery.

5. Quality assurance mechanisms need to be developed to evaluate and monitor allocation and distribution strategies to ensure that the fiduciary relationship between physicians and patients is not compromised by changing financial and delivery structures in the competitive health care marketplace.

6. Policies and strategies need to be revised frequently because new technologies and changes in availability may modify the current conditions.

Case Examples

These case examples were derived from stories from the field related by subcommittee members. They have been selected because they illustrate important ethical concerns. The committee is aware that in modifying them for presentation we have oversimplified some VA or DoD procedures.

Case 1

The director of the medical center must make a choice between the following two requests.

First Request

The chief of ophthalmology requests purchase of a binocular multiheaded operating microscope to teach and supervise residents in performing lens implants. With the binocular scope, the surgery could be performed more quickly and efficiently. Currently, the eyesight salvage on cataract patients is at least 400 to 500 patients per year. The cost of the microscope alone is $145,000.

Second Request

A VA patient who has had a heart transplant at a distant VAMC moves into this area to be near his parents and requests treatment at the local VAMC. His father is a Regional Office Director for the Congressional Representative. The patient is a Gulf War veteran who contracted viral myocarditis with rapid deterioration during the war. The VA medical center near his parents has not budgeted for the cyclosporine therapy and other anticipated or potential medical/surgical treatments required to maintain his transplant at a cost of $148,000 per year.

Ethical Considerations

The medical center director must make a choice because he has exhausted his designated equipment budget and must reallocate resources from another fixed budget source. The total amount of resources is finite. The binocular microscope will make it possible to treat 20-25% more patients (100 individuals) than are currently treated. In addition, the entire group of cataract patients will receive greater medical benefit because there will be overall fewer surgical complications, although the degree of this benefit is uncertain. The community will also benefit because these elderly patients will have substantially improved vision. They will be able to care for themselves more completely and require less assistance for their day-to-day needs. The treatment is considered "basic care" that has proven efficacy and allows the patients to enjoy the normal opportunities at their stage in life. Although the microscope is a one-time expenditure, the costs of surgery for the additional patients in each year will need to be considered and represents a commitment to future expenditures. The mission of this local VAMC includes education of surgical residents, and it is expected that some expenses will be incurred to provide a better learning environment.

In the second situation, a single identified individual has already been provided with sophisticated surgical care and VHA has an obligation to provide follow-up treatment. It is not clear that VHA should be obligated to minimize disparities in access due to geographic

location by providing his treatment locally, no matter where the patient chooses to live. The patient's right to self-determination and his choice to move nearer to his parents for his own convenience may need to be subjugated to the overall health care mission of the local VA hospital where he is now seeking care. This patient has a service-connected illness which was not directly caused by the performance of military duties. It was anticipated that his transplant and good follow-up care would provide significant (life-saving) benefit to the patient. He is relatively young and has a moderate chance of returning to full-time employment, and that prospect may be seen as a benefit to his family and the community. The requested expenditure is not a one-time allocation, but a recurring annual expense. The VAMC near his parents does not have as part of its local mission the provision of acute or long-term care for patients requiring organ transplants. The director expects that the patient's father may attempt to exert some influence through his political connections to get care for his son.

Procedural Considerations and the Director's Decision

After open discussion with the chiefs of ophthalmology, cardiology, rehabilitative medicine, pharmacy, and subspecialists at the tertiary care VA, the director decides to purchase the microscope. Although the transplant patient is an "identified" patient, the cataract patients are not a nameless group, but are currently being seen in clinic and can also be "identified" individually as needing surgery. Furthermore, future cataract patient load can be reliably predicted based on data from the past several years. The financial outlay of the two requests will be relatively equal each year. The additional costs related to surgery for the cataract patients will roughly equal the yearly cost of cyclosporin. However, rehabilitation costs for "blind training" for cataract patients that will not be required if they have surgery represent a potential cost savings for a different service.

A large group of patients will have significant medical benefit from the cataract surgery who would otherwise have had to wait a lengthy period prior to operation. Their overall outcome can be relatively accurately predicted. They are for the most part elderly and the length

of benefit for each patient may be only 5 to 10 years. The transplant patient has had life-saving benefit from his transplant and may attain near normal life function. However, his medical outcome is less certain and his ultimate life span may be no longer than that of the cataract patients.

The director believes strongly that VA has a special obligation to veterans with service-connected disabilities and that they should receive some priority in access to health care within VHA. He also understands that it is not within the scope of his VAMC's mission to provide follow-up care for transplant patients, and to do so would require him to limit care to some other group of patients in his medical center to whom he has already made a commitment. After discussion with the transplant patient, he agrees to provide travel funds for two visits per year to the tertiary-care VAMC, where the patient will obtain a six-month supply of cyclosporin and other medications and see the appropriate subspecialists for follow-up. The local VAMC cardiology service will see the patient regularly in clinic and monitor his progress. If he requires hospitalization related to his transplant, he will be sent to the tertiary-care VAMC. Funds will not be provided to his family for travel to accompany him. Although the director expects to hear from the member of congress, he believes his decision can be ethically defended and feels a responsibility to those patients already in the care of his VAMC who may not have powerful advocates.

The cataract patients will be queued for surgery. Priority will be given based on the magnitude of patient-centered medical benefit. This plan will take into consideration their other diagnoses, overall prognosis, prognosis for vision restoration with surgery, and other treatment options. For example, patients with diabetes who may have visual loss related to their disease will not be offered surgery or will be placed at the end of the line. This method of prioritization will be explained to each patient presenting with cataracts who may need surgery.

Case 2

Hospital budgets in Region X are severely reduced. Personnel chiefs

working with medical center directors cut occupational and physical therapist staffs by 50%. In response to the reduction in staffing, the chiefs of rehabilitative medicine service (RMS) in Region X met to assign priorities to the types of patients for whom their services would continue to provide care.

The chiefs agreed that they would no longer accept transfers from a military hospital of personnel with acute closed-head injuries who are on active military duty. (For the purposes of this case, we will assume that these patients are not immediately discharged from the military.) These patients normally require three months of acute rehabilitation at approximately $400 per day and an additional two months stay in a specially-staffed nursing home at $110 per day (a total of $42,600 per case). VHA has allocated only $9,000 per case to treat such patients and will not increase funds provided to the local VA medical center if costs exceed this limit. The unreimbursed expense to the individual VA medical center for each of these patients would be $33,600.

The average number of such patients (almost all under forty years of age) in Region X is 20 per year, resulting in an average expenditure per year of $672,000.

The chiefs of RMS preferred to apply these funds to rehabilitation of stroke patients who had potential for partial return of function and discharge to their homes. The average number of patients in this group is 500 per year and all are 60 years of age or older.

Ethical Considerations

Since their resources are finite, the chiefs of RMS in Region X must reduce their case load to accommodate the decrease in staffing. To accomplish this, they must limit access to beneficial health services for some group of patients. To justify rationing care, they must show that the savings will provide greater benefits to others, in this case the stroke patients.

Clearly the group of patients with head injuries will benefit from the treatment, which would be considered basic care. Most of them

will have full return to function and, since they are relatively young, they may have a number of productive years ahead of them. No one would suggest that they be denied care for their head injuries, but it is not at all clear that VA has as part of its mission the provision and financial underwriting of care for individuals on active military duty. It seems even less likely that individual VA medical centers would consider this part of their local mission and would be willing to divert funds from veterans in their care to support care of active duty military patients in peacetime. The head-injured patients have a powerful advocate in the Department of Defense, and the VHA personnel involved in this allocation decision need to actively consider the equally meritorious needs of other patients to whom they already have an obligation and who may not have forceful advocates.

The stroke patients also will benefit from the rehabilitative care, which would be considered basic care. Their medical outcome will be only a partial return to function, but it may enable them to resume personal care for themselves and make them less reliant on family and community resources in the long term. Their advanced age and partial return to function means that it is unlikely that any of them will return to the workforce, but they will be able to enjoy many of the normal opportunities at their stage of life. The large number of patients who would benefit from this rehabilitation will be reflected in significant cost savings for future VA and community resources.

Procedural Considerations

The decision-making process followed by the directors and personnel chiefs in making budget cuts seems to be ad hoc rather than based on a carefully thought out health care plan. As the case was described, they did not consult with either the chiefs of RMS or the occupational or physical therapy health care staff regarding their decision and its impact on patient care. The RMS chiefs continued this pattern by not consulting with their staffs or including military personnel in their decision-making process. Neither allocation/rationing decision was made in an explicit, public, and accessible manner, nor were representatives from all affected groups included in the process. Assessment of benefits and costs was limited to a small circle of individuals.

The rationing strategy used by the RMS chiefs could best be described as patient-centered, since they chose to ration (deny) care to a group of patients based on their clinical characteristics. To use this rationing strategy, one should focus on the medical benefit to each individual patient. In fact, if one compares the two groups under discussion, head-injured versus stroke patients, the head-injured patients would be most likely to have the greatest individual medical benefit from treatment. The social worth issues of younger age and higher productivity should not be used to justify choosing this group for treatment, nor should they be used to discriminate against the older less productive stroke patients.

The RMS chiefs cannot ethically justify their selection of the stroke patients over the head-injured patients based on individual medical benefit. The only defensible ethical basis for their decision must arise from their duty to give veteran patients priority for health care as part of the mission of VA and the local VA medical center. However, unilaterally refusing to provide care to the head-injured active military patients without assisting in developing a plan for care for future patients of this group would be abandoning patients for whom VHA, at some administrative level, has agreed to provide care. If budgetary constraints prevent a VA hospital from continuing to provide this care, then the system needs to search for other creative solutions that would enable the hospital to transfer care of these patients. These solutions could be sought internally within VHA or externally through a sharing agreement with the Department of Defense. In conclusion, although the decision that some rationing of care may be necessary and can be ethically defended, the procedures used for making rationing decisions in this case do not stand up to ethical scrutiny.

Selected Bibliography

Allocation of Scarce Resources

Gafni A, Birch S. "Guidelines for the Adoption of New Technologies: A Prescription for Uncontrolled Growth in Expenditures and How to Avoid the Problem." *Canadian Med Asso J* 1993;148(6):913-917.

Gill TM, Feinstein AR. "A Critical Appraisal of the Quality of Quality-of-Life Measurements." *JAMA* 1994;272(8):619-626.

Hastings Center Symposium. "Meeting the Challenges of Justice and Rationing." *Hast Cent Rep* 1994;24(4):27-42.

Jecker NS, Pearlman RA. "An Ethical Framework for Rationing Health Care." *J Med Phil* 1992;17(l):79-96.

Knaus W. "Ethical Implications of Risk Stratification in the Acute Care Setting." *Cambridge Q Healthcare Ethics* 1993;2(2):193-196.

La Puma J, Lawlor EF. "Quality Adjusted Life-Years: Ethical Implications for Physicians and Policymakers." *JAMA* 1990;263(21):2917-2921.

Morreim H, ed. "Ethics and Alternative Health Care Systems." *J Med Phil* 1992;17(1):1-117.

Murphy DJ, Finucane TE. "New Do-Not-Resuscitate Policies: A First Step in Cost Control." *Arch Intern Med* 1993;153:1641-1648.

Nord E. "The Relevance of Health State After Treatment in Prioritizing Between Different Patients." *J Med Ethics* 1993;19(1):37-42.

Truog RD. "Triage in the ICU." *Hast Cent Rep* 1992;22(3):13-17.

Ubel PA, Arnold RM, Caplan AL. "Rationing Failure: The Ethical Lessons of the Retransplantation of Scarce Vital Organs." *JAMA* 1993;270(20):2469-2474.

Health Care Systems and Allocation

Aaron HJ, Schwartz WB. "Rationing Health Care: The Choice Before Us." *Science* 1991;247:418-422.

American College of Physicians. "The Role of the Department of Veterans Affairs in Geriatric Care." *Ann Intern Med* 1991;115(11): 896-900.

Daniels N. "Why Saying No to Patients in the United States Is So Hard: Cost Containment, Justice and Provider Autonomy." *N Eng J Med* 1986;314(21):1380-1383.

La Puma J. "Quality-Adjusted Life Years: Ethical Implications and the Oregon Plan." *Issues Law Med* 1992;7(4):429-441.

Schaffner K, Morreim H, eds. "The Oregon Plan." *J Med Phil* 1994;19(4):301-394.

Schwartz WB, Aaron HJ. "Rationing Hospital Care: Lessons from Britain." *N Eng J Med* 1984;310(1):52-56.

Smith CB, Wolcott M. "Veterans Health Care: Lessons for a National Health Care System." *Ann Intern Med* 1991;115(11):907-909.

Allocation in Special Situations

Hadorn DC. "The Problem of Discrimination in Health Care Priority Setting." *JAMA* 1992;268(11):1454-1459.

Hunt RW. "A Critique of Using Age to Ration Health Care." *J Med Ethics* 1993;19(1):19-23.

Jecker NS, Berg AO. "Allocating Medical Resources in Rural America: Alternative Perceptions of Justice." *Soc Sci Med* 1992;34(5):467-474.

Joint International Research Group of the Institute for Bioethics and The Hastings Center. "What Do We Owe the Elderly? Allocating Social and Health Care Resources." *Hast Cent Rep Special Supplement* 1994; 24(2):Sl-Sl2.

Pawlson LG, Glover JJ, Murphy DJ. "An Overview of Allocation and Rationing: Implications for Geriatrics." *J Am Geriatr Soc* 1992;40:628-634.

Thomasma DC. "Functional Status Care Categories and National Health Policy." *J Amer Geriatr Soc* 1993;41(4):437-443.

Health Care Reform

Brock DW, Daniels ND. "Ethical Foundations of the Clinton Administration's Proposed Health Care System." *JAMA* 1994;271(15): 1189-1196.

Emanuel EJ, Brett AS. "Managed Competition and the Patient-Physician Relationship." *N Eng J Med* 1993;329(12):879-882.

Wolf SM. "Health Care Reform and the Future of Physician Ethics." *Hast Cent Rep* 1994;24(2):28-41.

Physician/Patient Relationship

Angell M. "The Doctor as Double Agent." *Kennedy Inst Ethics J* 1993; 3(3):279-286.

Brody BA. "Physicians and Rationing." *Texas Med* 1991;87(2):86-90.

Emanuel EE, Emanuel LL. "Four Models of the Physician-Patient Relationship." *JAMA* 1992;267(16):2221-2226.

Pellegrino ED. "Rationing Health Care: The Ethics of Medical Gatekeeping." *J Contemp Health Law Policy* 1986;2:23-45.

Reed RR, Evans DR. "The Deprofessionalization of Medicine: Causes, Effects and Responses." *JAMA* 1987;258(22):3279-3282.

Sugarman J, Powers M. "How the Doctor Got Gagged: The Disintegrating Right of Privacy in the Physician-Patient Relationship." *JAMA* 1991;266(23):3323-3327.

Sulmasy DP. "Physicians, Cost Control, and Ethics." *Ann lntern Med* 1992;116:920-926.

Welch HG. "Should the Health Care Forest Be Selectively Thinned by Physicians or Clear Cut by Payers?" *Ann Intern Med* 1991;115(3): 223-226.

Books, Reports, and Bibliographies

American Medical Association, Council on Ethical and Judicial Affairs. "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources among Patients." *Code of Medical Ethics Reports* 1993; 4(2):140-173.

American Medical Association, Council on Ethical and Judicial Affairs. "Ethical Issues in Managed Care." *Code of Medical Ethics Reports* 1994; 5(2):276- 289.

Callahan D. *Setting Limits: Medical Goals in an Aging Society*. New York: Simon Schuster, 1987.

McCarrick PM. *A Right to Health Care*. National Reference Center for Bioethics Literature, 1992; Scope Note 20:1-13.

McCarrick PM. *The Aged and the Allocation of Health Care Resources*. National Reference Center for Bioethics Literature, 1993 (revised); Scope Note 13:1-13.

Menzel PT. *Strong Medicine: The Ethical Rationing of Health Care*. New York: Oxford University Press, 1990.

Walters L, Kahn TJ, eds. "Resource Allocation," in *Bibliography of Bioethics*, Washington, DC: Georgetown University Press, 1994;20: 539-560.

Winslow GR, Walters JW, eds. *Facing Limits: Ethics and Health Care for the Elderly*. Boulder, CO: Westview Press, 1993.

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