



Fairness in health care

Implicit rationing?

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Do as much good as possible:
Effectiveness,
efficiency, safety

Be fair and aim for
equal access:
Fairness, equity,
solidarity

Our health systems

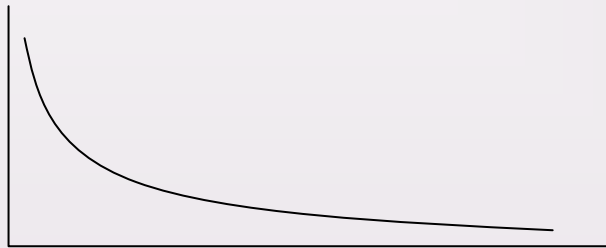
Legitimate decision processes, democracy, transparency,
accountability

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We must have limits

- Part of the debate on health care rationing hinges on whether our resources are limited
- The answer is actually clear: they are.

Small exercise: how many ambulances do you need in a town like Olten?



Should we ration care?

- It depends!
 - Should we withhold a very effective and expensive treatment from a person who needs it acutely?
 - Probably not!
 - Is it always morally wrong to withhold an intervention with a marginally small and/or very uncertain benefit?
 - Probably not...

The question is not *whether* but *how*

We must have fairness

We are good and fair beings, or course!

Because our health-related needs are not predictable and group needs are..



Need for insurance and solidarity

Or at least we recognize the right for all to have access to health. OMS 1998

Because we do not know who will be impoverished by disease

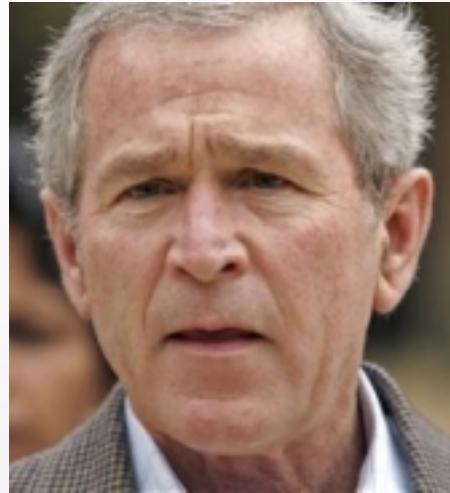


A system that leaves the poor and the chronically ill aside puts us all at risk

Or we defend equal opportunity for a full range of life options, and health is a pre-requisite for this. Daniels *Just health care* 1985

Fairness is not obvious

Vaccarino et al.
Sex and racial differences in the management of acute myocardial infarction, 1994 through 2002.
NEJM.2005;353(7):671-82



?



Escher M,
Perneger TV,
Chevrolet JC.
National Questionnaire survey on what influences doctors' decisions about admission to intensive care.
BMJ
2004;329:425

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Fairness is not obvious

- Health is socially stratified...
- So is access to care...
- And the efficacy of certain interventions...
- Therefore, the degree of insurance risk...
- ...and sometimes the doctor's reaction.

**Implicit rationing can take place at many levels,
and raise different problems at each one...**

The Values at the Bedside study

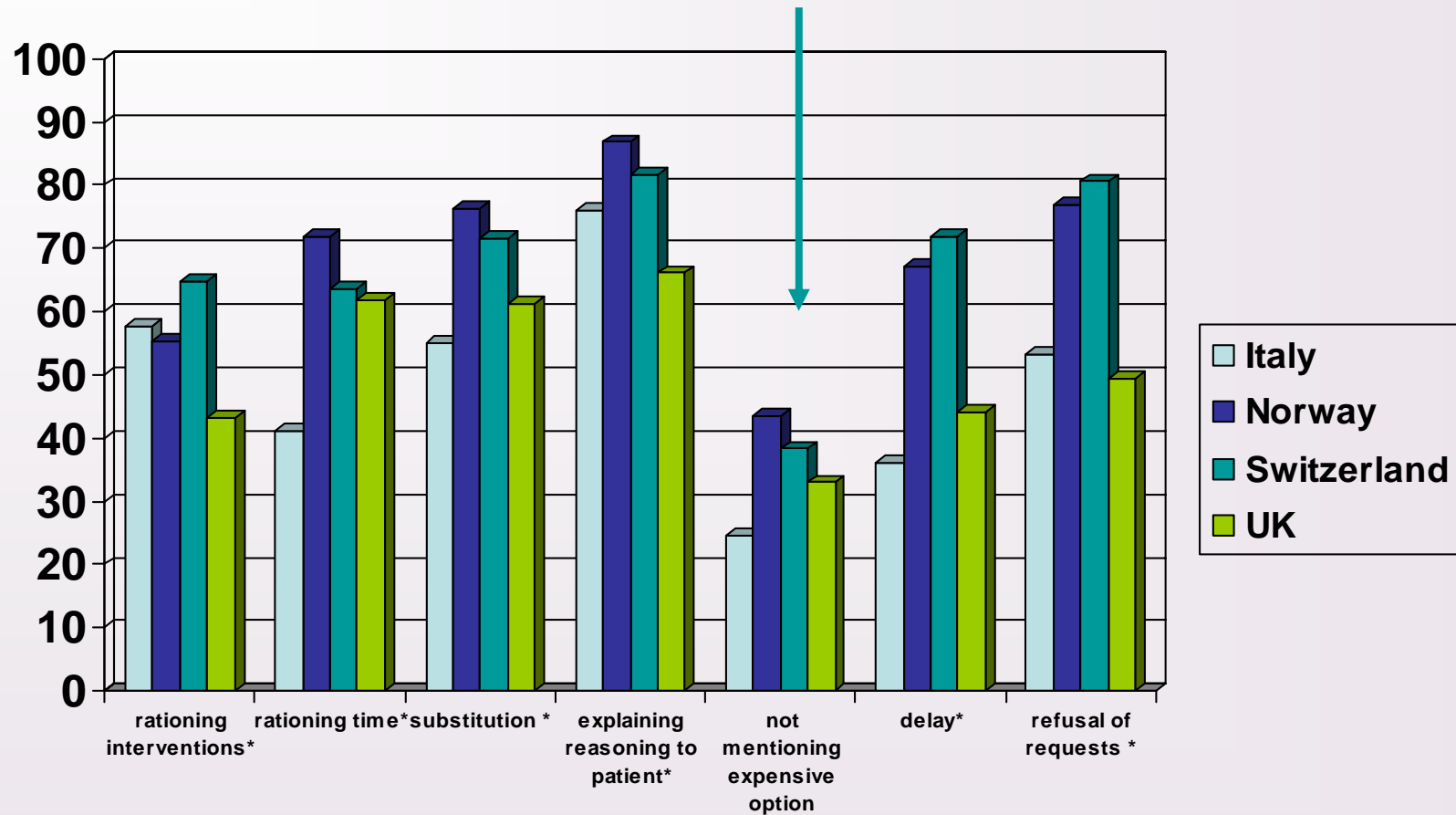
- Do physicians ration care?

Hurst S., Slowther A., Forde R., Pegoraro R., Reiter-Theil S., Perrier A., Garrett-Mayer E., Danis M.: *Prevalence and Determinants of Physician Bedside Rationing: Data from Europe*. Journal of General Internal Medicine.

2006;21(11):1138-1143

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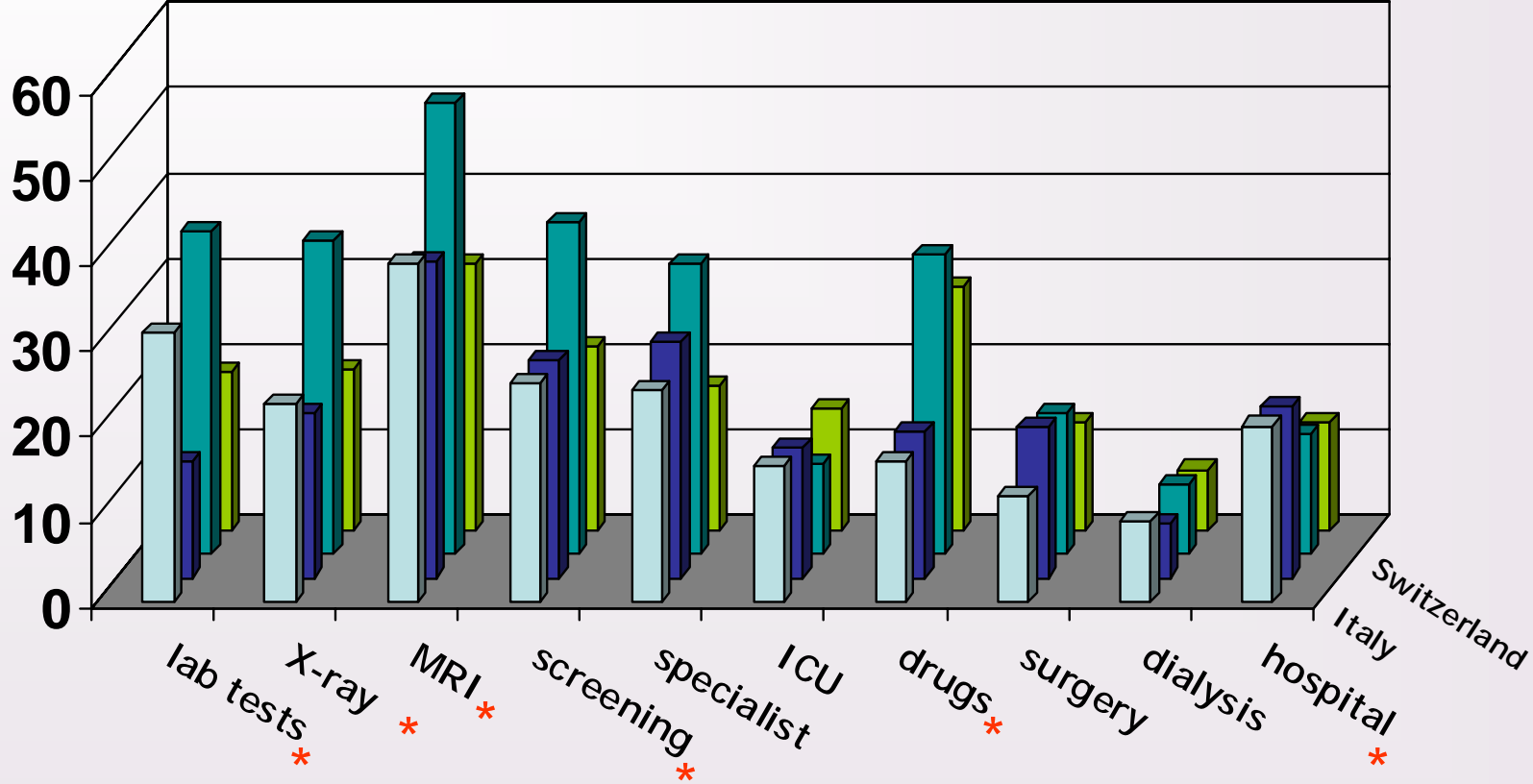
Reported Limits



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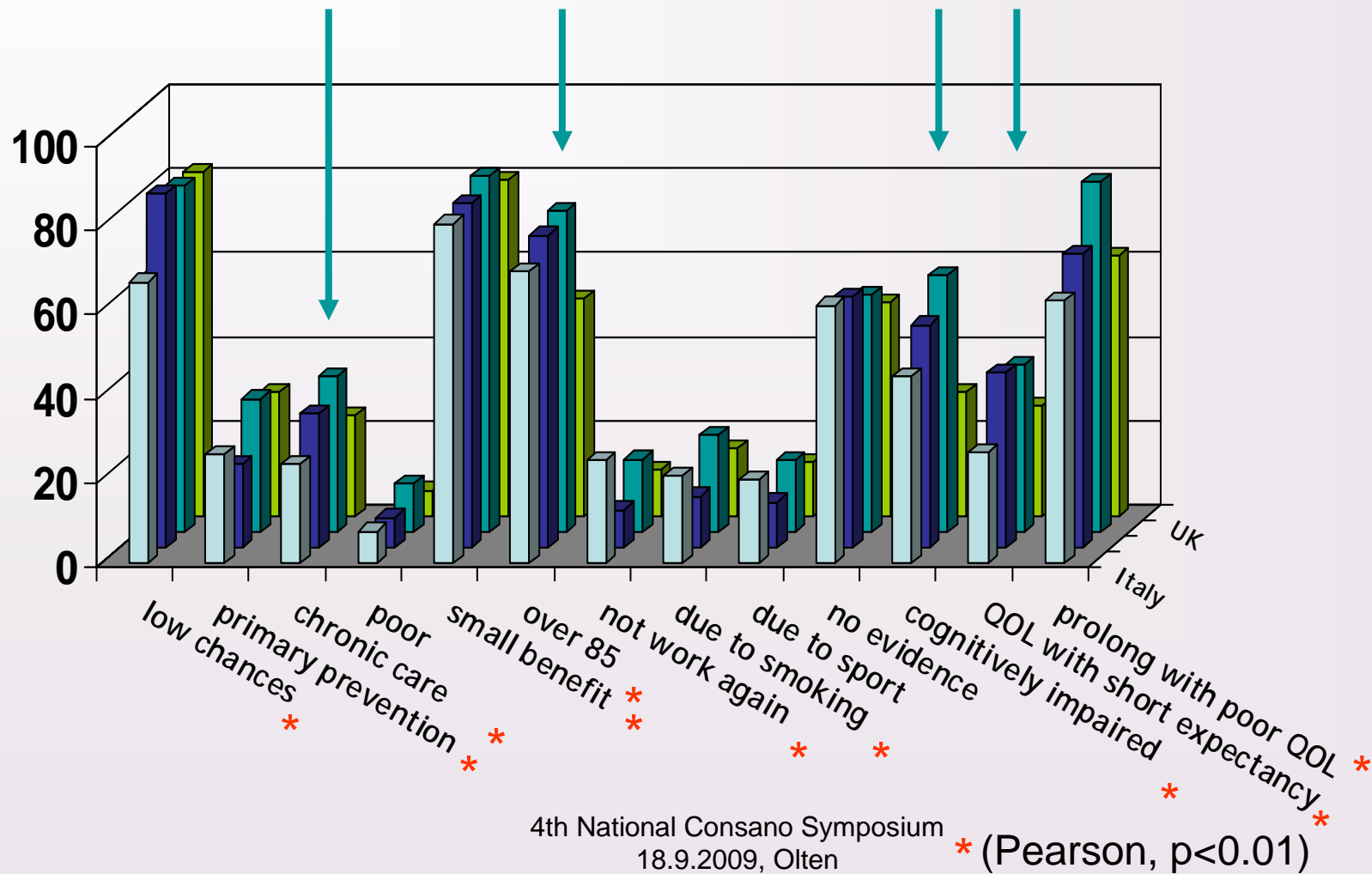
*(Kruskal-Wallis, $p < 0.01$)

Types of Interventions Rationed



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 18.9.2009, Olten * (Pearson, $p < 0.01$)

Reported Criteria Used for Rationing



Determinants of rationing

Variable	Odds ratio*	95% CI
Perceived scarcity	1.11	1.06-1.16
Pressure to ration	2.14	1.52-3.01
Agreement with rationing	1.13	1.05-1.23
Norway ‡	2.61	1.34-5.06
Italy ‡	3.62	1.65-7.91
Switzerland ‡	5.1	2.28-11.68

???

Methods in limit-setting

- Our data suggests two kinds of differences between the 4 systems
 - Differences in health care expenditure
 - Differences in the latitude given to physicians
 - Some are **constrained by scarce resources**, and make fewer rationing decisions.
 - Some are given **freedom under pressure**, and make more rationing decisions.

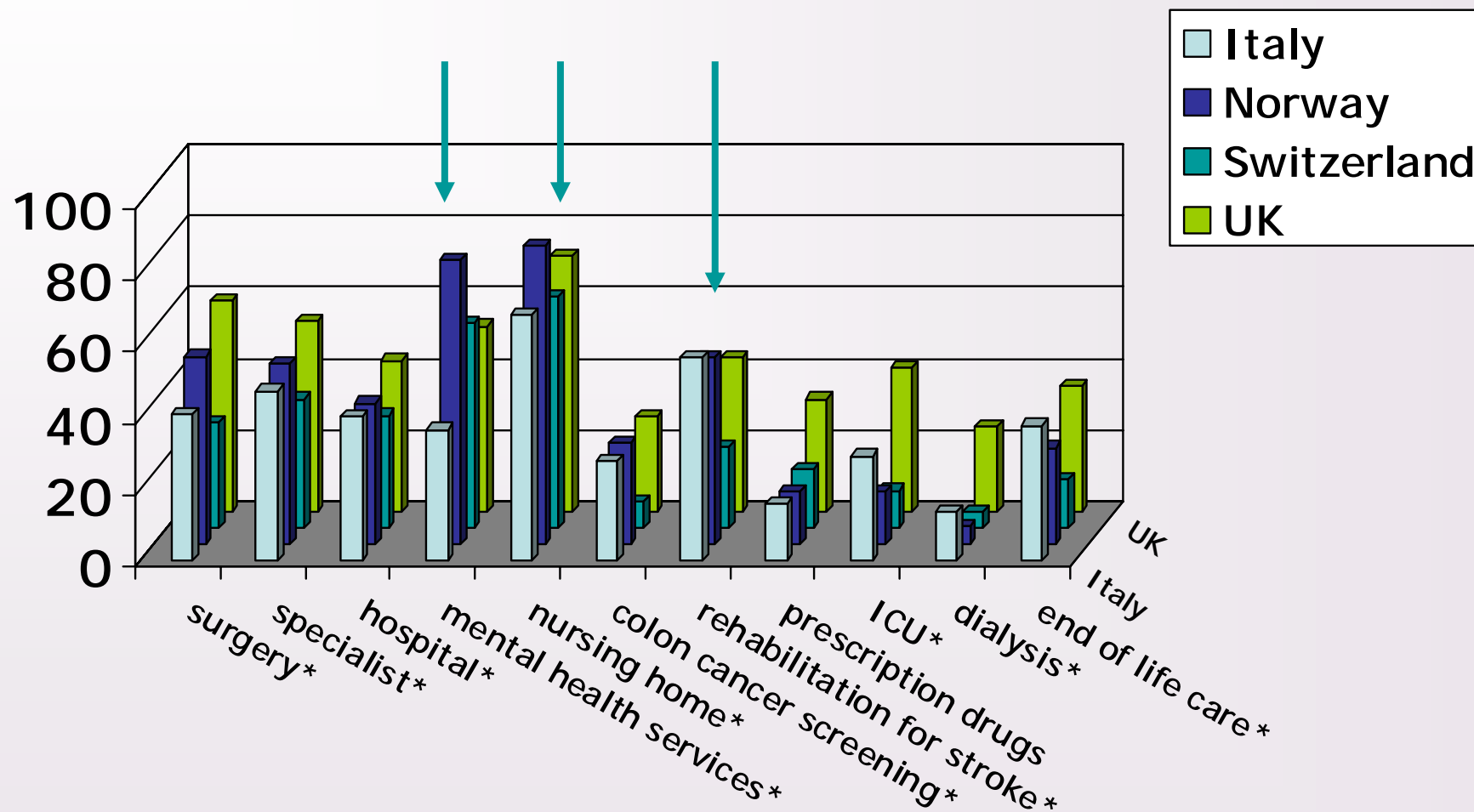
Perception of limits

During the last **six months**, how often were you unable to obtain the following services for your patients when you thought they were necessary (this includes unacceptable waiting times)?

*Kruskal-Wallis, $p < 0.001$

Country	Some scarcity	Mean*
Italy	83.3%	7.73
Norway	91.6%	7.35
Switzerland	83%	4.17
UK	92.1%	9.36

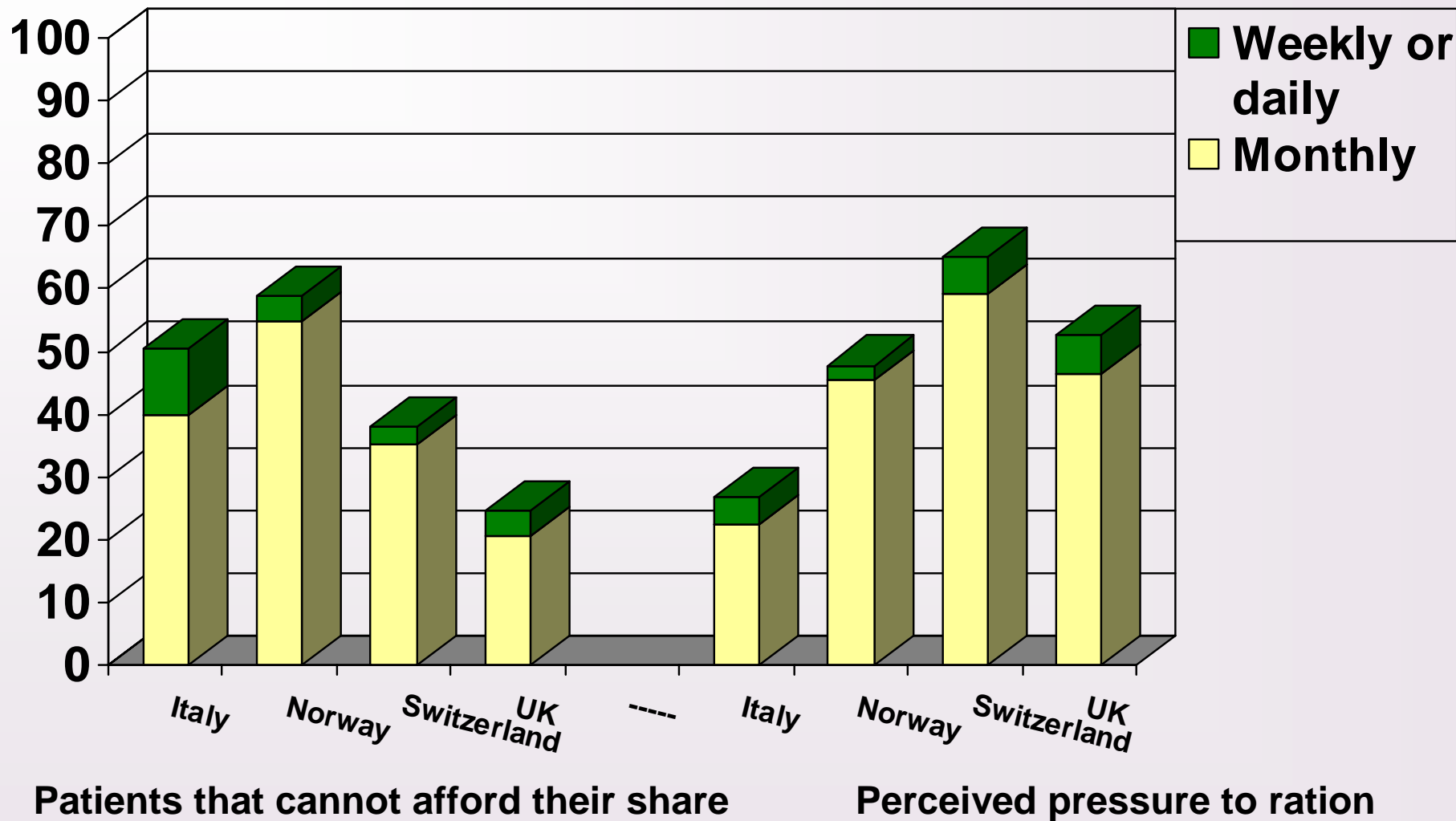
Limits by scarcity



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(Pearson, $p < 0.01$)

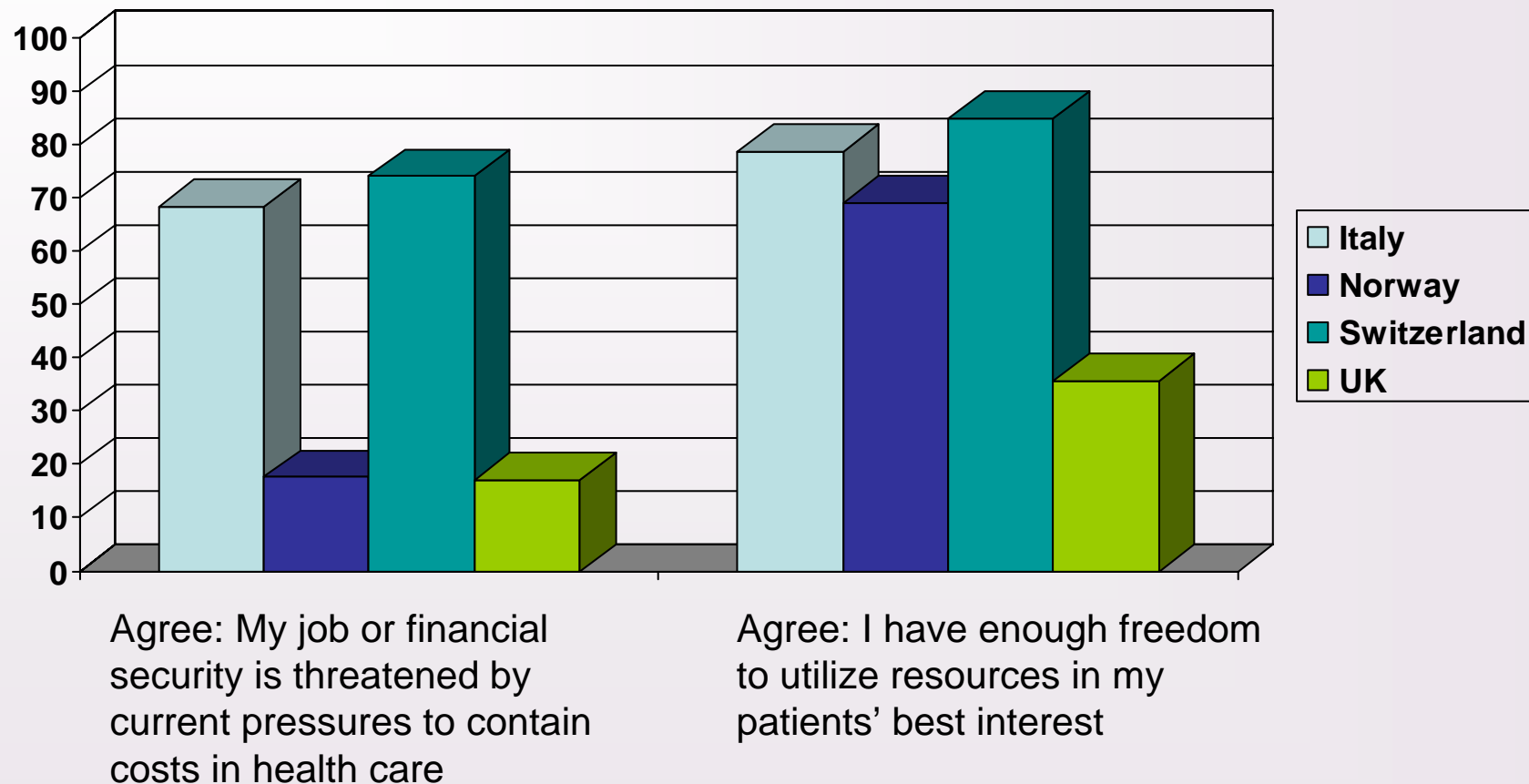
Limits by co-pays and pressure



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Kruskal-Wallis: $p < 0.001$

Pressures and constraints



Fairness is not obvious

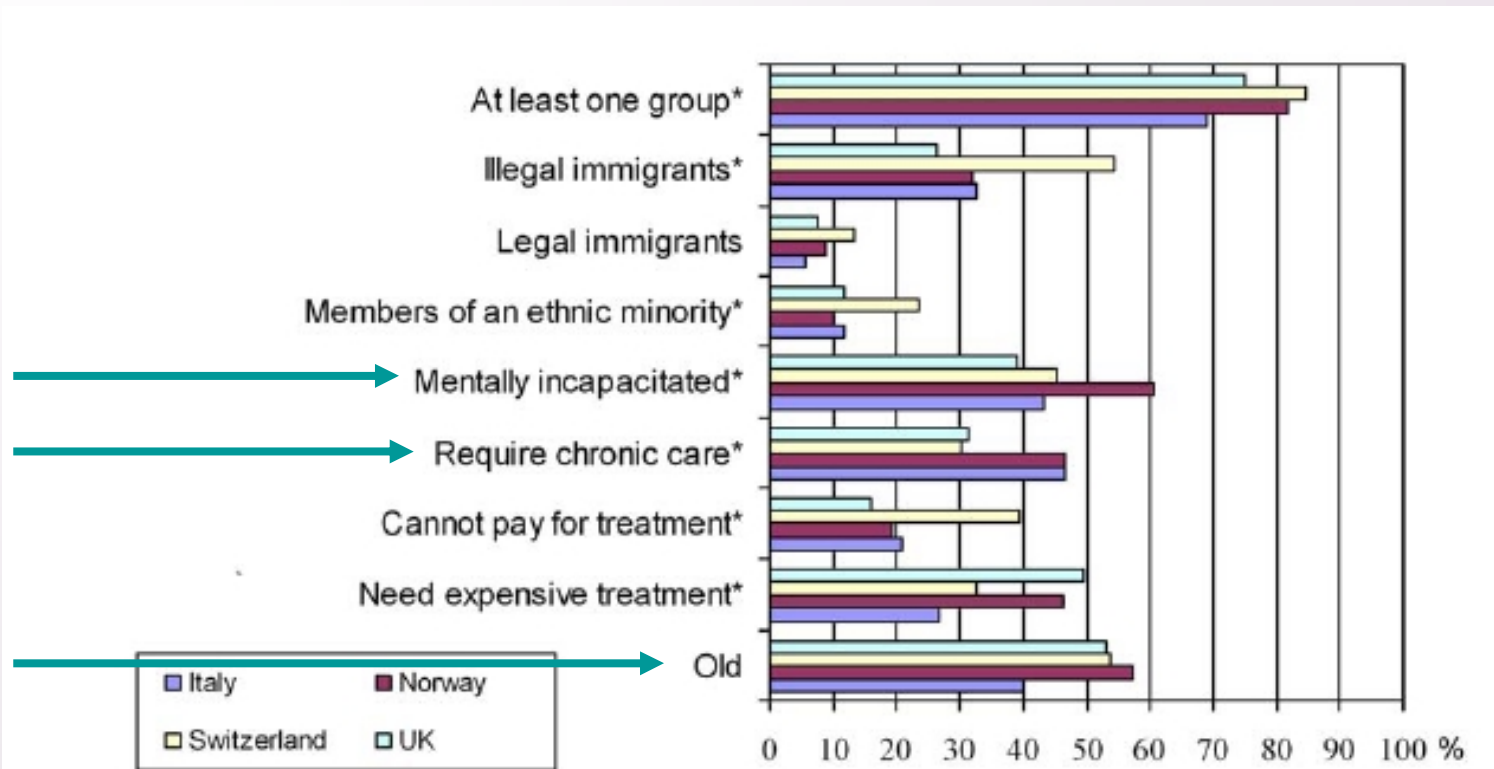


Figure 2

Reported greater likelihood to be denied treatment based on group identity. Based on your experience, are patients who belong to any of the following groups more likely than others to be denied beneficial care on the basis of cost in your health care environment?. *Pearson Chi-Square: $p < 0.01$; null hypothesis is "no difference".

Behind our data, a question

With more elbow room, but more pressure, a greater part of limit-setting falls on individual doctors

Question: is it better to have doctors who personalise under pressure, or doctors who impersonally apply rules?

Perhaps it depends, but this is what we should discuss.

*And in Switzerland we have an answer to this sort of question: **neither, a little of both...***

Methods and risks

Adapt to individual's needs and priorities?

But micro-level decisions are prone to bias, and lack transparency...

Do the same for everyone?

But individuals are complex: we risk being blind to this and obtaining unfair outcomes...

Here too, we need balance

Adapt to individual's needs and priorities:
Explicit process,
based on general
rules, with leeway for
adaptation in
individual cases...

Do the same for
everyone:
General guidelines,
publicly available,
open to revisions,
with appeals
procedure...

Setting limits in our health systems

Goold and Danis: *CHAT: a deliberative exercise for allocating limited health care resources*. 2005

Hurst and Danis: *A Framework for Rationing by Clinical Judgment*. 2007

Daniels et Sabin, *Setting limits fairly*, 2002

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Thank you

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And all the busy physicians who answered our questions!