ALLOCATING SCARCE RESOURCES IN A PUBLICLY FUNDED HEALTH SYSTEM: ETHICAL CONSIDERATIONS OF A CANADIAN MANAGED CARE PROPOSAL

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In the Canadian health care system, the Government is responsible for allocating scarce resources in a fair and equitable manner. A proposal to implement managed care as a method of reimbursing physicians in Alberta, Canada, needs careful ethical consideration, because physicians are not well prepared, and should not be asked, to make the resulting difficult allocation decisions. The Government must continue to be held responsible for ensuring that all citizens have equal access to necessary medical services, and we must find ways to encourage the public to become more involved in deciding how resources are best allocated. Health professionals other than physicians must take an interest and enter into this debate.

The allocation of health resources is an important ethical issue that needs attention and discussion at public level. All too often, decisions about allocating these scarce resources are made or evolve without participation from front-line health workers or the patients who are ultimately affected. One such example is the ongoing consideration of a new remuneration system for physicians in the province of Alberta, Canada, which is based on the principles of managed care and, if adopted, would make an impact on the health system as a whole and also change the way in which health resources are allocated. In a completely publicly funded health care system as in Canada, undertaking change of this nature requires particularly careful consideration, not only by the negotiating parties but also by citizens in general, and especially by other health care professionals who have knowledge of the system and can make informed contributions to ethical discussions.

The Alberta Medical Association developed a proposal in 1995 for a new way

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to reimburse physicians for services provided. This proposal, Fee for Comprehensive Care (FCC),[1] is a type of managed care plan based on a capitation payment (one annual fee for the care of one patient regardless of the number of services provided). This was developed in response to Government initiatives to increase cost-effectiveness and efficiency within the health system, and refocus attention on to the maintenance of health rather than the treatment of illness. Five years later, in 1999, the proposal has neither been accepted nor rejected, nor has it undergone thorough analysis of its potential effects on the health system. Experience with managed care in other parts of the world, particularly the USA, has shown that financial incentives alter the behaviour of physicians.[2] In the Canadian system, where all citizens are assumed to have an equal right to health care services based upon medical need, it is important to understand the ethical implications of how scarce health care resources may be allocated if such a proposal were implemented.

The FCC proposal provides a voluntary, alternative payment plan for physicians in which, rather than being reimbursed for each service provided, they would receive lump sum funding to provide all the necessary physician services for their registered patients within a specified time period. Within this FCC plan, physicians could delegate the actual provision of services to other professionals such as nurses or dieticians, which is not currently allowed. There are several likely advantages of implementing the FCC proposal. First, any move away from fee-for-service remuneration is likely to reduce overall costs because physicians will have less incentive to see patients frequently.[3,4] Secondly, because physicians would receive a specified dollar amount per patient whether he or she is healthy or ill, they will be encouraged to focus on keeping people healthy rather than treating illness, which is consistent with a stated government objective of 'keeping Albertans healthy'.[5] Finally, the use of lower cost professionals, such as nurse practitioners, could reduce overall costs. However, ethical concerns regarding the effects of FCC on the patient–physician relationship, and on citizens' rights to access health care services, need much greater attention before it is implemented beyond the current limited trials.

Under the present Canadian health care system, every citizen is guaranteed access to all 'medically necessary'[6] health care services without any personal expenditure. Although there is no established definition of 'medically necessary', it has been interpreted broadly by the Federal Government to include almost all physician, hospital and diagnostic services. Health is a provincial responsibility under the Constitution Act, 1967,[7] and is financed through a combination of provincial and federal funding. The Canada Health Act[6] allows the Federal Government to withhold transfer payments to the provinces if they fail to provide necessary services or allow health providers to charge individual patients. Everyone accesses the public system regardless of their ability to pay for services. Physicians play a key role in the Canadian system, acting as gatekeepers who control patient access to hospital, nursing home, diagnostic and all other services, and, because they have a central role, the way in which they are reimbursed for their services affects most other parts of the system. For example, physicians are currently paid by fee-for-service (FFS). That is, they invoice the Provincial Government for every office visit, hospital visit or procedure performed, and are then paid according to a negotiated fee schedule. Under this plan, a physician

can maximize his or her own income by performing an increasing number of services, but the actions of the physician in admitting patients to hospital or ordering diagnostic tests will also have an impact on hospital costs (driven by an increased demand for hospital workers such as nurses, technicians, etc.) and on expenditures for other specialists such as radiologists or pathologists, which are all borne by the Provincial Government. Although they are not directly affected by physicians in their gatekeeping capacity, almost all health professionals are indirectly affected because if, for example, physicians significantly reduce the number of patients referred for hospital admission, counselling or diagnostic procedures, nurses and other health professionals will face layoffs as hospitals downsize accordingly.

The allocation of resources becomes an ethical issue when there are insufficient resources to satisfy every need and when there is an established right of access to these resources.[8] Canadian waiting lists for medical procedures show that demand exceeds the publicly provided resources available,[9] but the public have so far tolerated moderate waiting times that allow those who are most in need to receive priority treatment. There is ongoing debate in the American health-based literature regarding whether or not all citizens have a right to health care,[8,10] but it seems apparent through public opinion polls, and through the widely accepted provisions of the Canada Health Act, that Canadians believe that all residents of the country have a moral right to publicly funded, medically necessary health care. The reliance upon public opinion to assess a moral right has been argued by Hegelian philosophers such as TH Green and Bernard Bosanquet, who contended that public opinion is a suitable indicator of moral right because convictions of society represent the most advanced stage in the unfolding of a rational morality.[11] Thus, according to the philosophical reasoning of Jeremy Bentham and John Austin, if a moral right exists, there is a corresponding moral duty implied,[11] in this case, upon the Provincial Government to ensure that individuals are able to exercise that right. However, when the Provincial Government does not have sufficient resources (or chooses not to allocate sufficient resources) for all medically necessary treatments to be provided, then a situation of scarcity exists, the principle of justice comes into play, and it is incumbent upon the Government to allocate health resources in a just and fair manner.

With the current FFS system, physicians can increase their own income by seeing patients frequently. The Government has attempted to control overall physician costs by imposing a global cap on total physician expenditures, and has charged the Alberta Medical Association with the responsibility of enforcing that limit. In the last fiscal year Alberta physicians billed the provincial plan for $70 million over that limit, so it seems that this solution to reducing costs has not been completely successful.[12] Moving to a FCC system of remuneration would impose a limit on expenditure by each physician or each group of physicians who contract with the Government to provide all necessary medical care for a number of patients for a flat rate. Under this system, physicians could maximize their income by contracting to care for a large number of patients and would have no financial incentive to provide any services. Thus, financially, the ideal patient is one for whom the physician receives annual funding, but who requires no health care services. The resulting focus on wellness and prevention of injury and disease is obviously desirable, but a system such as FCC relies upon physicians'

sense of professional duty to provide sufficient services for those who need them, regardless of the cost.

FCC or another form of managed care can also be seen as an attempt on the part of the Government to pass the responsibility for the fair distribution of scarce resources on to individual physicians, who would be faced with dividing up their time among their own patients. The American experience indicates that significant cost savings cannot be realized from managed care plans unless physicians are also given incentives for reducing the number of treatments or surgeries in hospitals, X-ray or laboratory tests ordered, and all other procedures involving the use of ancillary health personnel or equipment.[13] Thus, it seems likely that FCC, which only involves actual physician services, would be enlarged in the future to include control over the gatekeeper functions of physicians. It is through incentives to encourage physicians to reduce overall health care procedures that the Government could realize significant cost savings and this is where important ethical considerations may arise.

Increasing the costs of health care and the decreasing tolerance of citizens for taxation have combined to bring about a new economic reality for the provision of health services throughout the western world. Morreim[14] argues persuasively that, because of technological advances, an increasingly ageing population, and the labour-intensive characteristic of today's health care systems, the cost of services has become an unavoidable issue. He proposes that, instead of bemoaning the difficulties of providing services within a cost-sensitive atmosphere, we should use these economic realities to our advantage by first accepting the need to consider cost when planning appropriate treatments and also by recognizing that those who pay the health care bills, whether it is individuals, insurance companies or governments, must be allowed input into how resources are allocated.

Morreim brings interesting points to bear on the ethical implications of these new economic realities that are particularly applicable to American-style health care, but are also of interest in considering the Canadian experience. Since we in Canada have entrusted our Government with managing health care on a public basis, we rely upon our elected officials to allocate resources in a way that achieves the best results for the public as a whole. This system creates some significant differences from the system in the USA in that individual rights may sometimes conflict with policies that aim to maintain a healthy population, some members of the public are more vocal and therefore more influential than others, and physicians are the key gatekeepers in controlling access to government-provided resources. With only one payer for health services throughout the province, the Alberta Government, through the regional health authorities, faces decisions such as whether to allocate funds to increase the number of neonatal intensive care unit beds available, or to use that money for hot school lunches in low-income areas. If there are insufficient public resources for both, decision makers face morally difficult questions regarding the relative value of a small number of low birth weight babies who may be saved versus improving the nutrition, and thus the overall health status, of many underprivileged children. Similarly, the Government must deal with relatively wealthy and sophisticated members of the public who may bring great pressure to bear in favour of doing everything humanly possible for the one child from a high-profile family, even though the baby's survival chances are very poor, compared with low-income residents who

feel powerless to argue for small per capita expenditures for their children, which are highly likely to result in improved educational and health status. Finally, the Government must find ways to reimburse physicians adequately for their time and expertise in providing health services, but also attempt to provide financial incentives that will encourage doctors to perform their gatekeeper functions in ways that complement overall government policies of cost-effectiveness. It is primarily because of this final point that the Provincial Government strives to move away from a FFS compensation system, and possibly towards FCC as a method of rewarding physicians for keeping their patients healthy, or for providing as few health treatments as possible for each patient. It is in this attempt to induce physicians financially to adopt cost-reducing strategies that many of the difficult moral questions currently faced by government representatives at a policy level would be pushed down to physician level.

Many ethicists have argued the need to make health resource allocation decisions at a policy level and not at the bedside[10,15] but, as cost considerations become more important, and as physician reimbursement schemes such as managed care, health maintenance organizations and FCC become more prevalent, doctors *are* being forced to make allocation decisions at the bedside. Even if general guidelines are made at higher levels, it remains the case that efficiency will not be achieved until physicians take action to reduce the use of high-cost treatments.[14] The current proposal of FCC would entail physicians in making decisions on a daily basis regarding which patients receive large amounts of their time and which receive relatively less. In the future, if physicians are also rewarded for minimizing overall health costs, they would be required to choose which patients receive expensive treatments and which ones could recover with less expensive interventions or possibly with no intervention at all. Physicians, as part of their health care role and professional status, have always been charged with making decisions about the effectiveness and suitability of potential treatments, but to link this with information about the cost of such treatments and how that will affect their own income brings a new dimension to the decision-making process. Physicians would be asked to allocate resources between individuals who are all known personally to him or her; this situation would inevitably create a conflict of interest or, as Angell has suggested, turn doctors into double agents.[16] Some ethicists have argued that emotion should be avoided in distributing resources because decisions made will be inherently flawed,[15] but others have suggested that moving allocation decision making to the bedside will bring the ethical focus back to its proper level of the individual.[17]

Whether or not such a system would bring an improvement in allocation decision making, it will almost surely result in more variety in how allocations are made, threatening the Canadian right of equal access to health care based on need. Some physicians may choose to spend more time and resources on the young compared with the old,[18] while others may feel justified in expending relatively larger amounts on patients who have a healthier lifestyle. None of these choices could be considered ethically wrong, given public support for the appropriate way to determine equality and fairness in times of scarcity, but, in a health care climate such as currently exists in Alberta, it is important to consider that such variations are likely to result from a FCC system. Although physicians adhere to a deep sense of professionalism that tends to minimize the variability

of allocation decisions, FCC physicians would continually face great personal pressures to somehow balance appropriate levels of treatment, prevention initiatives and the needs of one patient compared with another, all within a global limit on expenditures that relate directly to his or her own income. As a society that supports universal health care, we must give careful consideration to whether it is appropriate to ask this much of physicians.

From a physician's perspective, it is important to consider what physicians' moral duties with regard to a government-imposed limit on their overall treatment costs might be. In moving to a FCC reimbursement scheme, physicians would be expected to fulfil both a public health and a medical role. Mann[19] has pointed out how these two approaches require opposing models. While public health is built on a population-based approach, where the needs of the group as a whole are paramount, medical care is based upon meeting the needs of individuals. If faced with a conflict between the two goals, such as expensive neonatal care for one patient versus nutritional services for many, whose needs do we as society want physicians to consider as supreme? Based on physicians' professional obligations and sense of beneficence for each of their patients, we might expect the medical model to be considered most highly, but, if physicians are compensated so that it is in their financial interest to minimize overall expenditures by maximizing the health of the group, the public health model is more likely to prevail. Physicians may find that they are torn between their sense of beneficence and professionalism, and the financial incentive to adhere to public health objectives. Universal guidelines developed at the medical association level may be helpful to physicians in determining which treatments to provide and in which patients to invest relatively larger or smaller resources, but guidelines will not cover all eventualities.[14,17] Blanket bans on specific treatments will not always seem appropriate.[20] Thus, the evidence continues to grow of the great inherent reliance upon physicians under FCC to distribute resources in a fair way, taking into account need and probability of success, and making such decisions without such a high degree of emotional involvement that judgement is impaired. Subject to review by their peers, it would be up to physicians to determine whether individual needs should prevail over those of the group or vice versa, and it would be up to physicians to defend the decisions made, to themselves and to others.

One particular area where physicians have traditionally had a large input into how resources are allocated is in making decisions for patients who are considered to be mentally incompetent. Buchanan and Brock[21] have pointed out the importance of ensuring that those who are incapable of speaking for themselves do not move to the bottom of the list with respect to access to resources. They argue that the usually high costs associated with the end stages of life, when people are often incompetent to make decisions, should be spread throughout society rather than contained within a small group such as a managed care group. This suggests that it would be extremely difficult and unfair to expect FCC physicians to decide whether one patient should be maintained on expensive life support systems while family members come to terms with that person's impending death, given that such an expenditure will reduce amounts available for others. Similarly, patients with chronic illnesses who require ongoing expensive medical care are a financial burden to a managed care plan, and decisions must be made about how many services to provide for the chronically ill, or even whether to

accept them as patients within a managed care group. This type of difficult ethical decision making is the basis for cost savings under a managed care system, when physicians will be motivated to reduce such costly life-support or chronic care services when potential long-term improvement is minimal, and when those resources could be better used by other patients.

Earlier I have argued that, in Canada, citizens hold a moral right to health care, which imposes a moral duty upon the Government to distribute health care resources fairly among citizens. In proposing to reimburse physicians by a mechanism that provides incentives for reducing overall costs, the Government may be attempting to discharge its responsibility of fairly allocating health services to physicians. It is important to question whether this is appropriate. Loewy[15] suggests that physicians cannot be gatekeepers of communal resources because they are trained to act as advocates for individual patients. Their focus on individual needs is in direct opposition to the concept of communal resources, which should serve the purposes of all citizens. This view is also expressed by Bell,[22] who describes failed attempts to make physicians focus on community needs, when, instead, their treatment plans and way of thinking continued to revolve around individual needs. Thus, it seems, under FCC, the Government would be discharging its moral obligation to distribute scarce resources to a group who have consistently shown their strong inclination to favour individual needs over public health. In order to counter physicians' tendencies to provide as many treatments as remotely appropriate, this strategy asks individual physicians to consider the overall cost implications because they will be personally rewarded for providing as few services as possible. We should not allow the Government to discharge its moral responsibilities so easily. Government representatives need not make allocation decisions themselves in order to ensure fair distribution, but if they rely upon others (in this case physicians) to make cost–benefit decisions, then the onus must remain upon the Government to ensure that the system established is one that is likely to result in a fair and equitable distribution. Physicians will have great difficulty in representing the interests of their patients while at the same time reducing overall health care costs, and the Government must be cognizant of this potential conflict of interest.

Members of the public have shown increasingly their desire to have input into decisions relating to health care.[23–25] In Canadian-style health care, where taxpayers are the primary payers, the importance of public input is undeniable. Morreim[14] points out the ethical necessity of health care providers, explaining to patients that, for example, the managed care plan they are insured under provides a financial incentive to the physician if they spend only 24 hours in hospital for a particular surgical treatment compared with several days. He also argues that the new economic realities mean that physicians have a duty both to understand cost issues relative to medical treatment and to inform patients about the long-term financial effects of a particular medical action. Such an increased focus on the need to inform members of the public, patients or potential patients about medical costs should be applied to the proposed FCC remuneration plan in Alberta. Switching to such a managed care system, especially if incentives to reduce overall health care expenditures are implemented, is likely to be of great significance to members of the public, but, for the most part, Albertans are ill-informed about what the effects of such a system are likely to be. Whether FCC

becomes the choice method of physician remuneration or not will be determined behind closed doors during physician fee negotiations with government representatives. Both the Government and the physicians state that they negotiate with the best interests of the public in mind, but the Government's focus is on reducing overall health costs and the physicians' focus is on maximizing physician revenues. The Government relies upon the professionalism of physicians to assure that quality health services are provided, and physicians rely upon their professionalism to assure that health care services are maintained, no matter how physicians are reimbursed. More open discussions that include the public perspective regarding how physicians are paid would take into consideration the desire and right of ordinary Albertans to have a say in how they are able to access scarce health resources.

Summary and conclusions

It is important to consider the impact of reimbursing physicians under a FCC system from an ethical perspective because such a change is likely to have significant effects on how health care resources are allocated. Canadians take pride in their publicly funded health care system, which is equally accessible to all citizens, but cost pressures threaten its very basis. Although the reality of paying for health care services must be part of planning for the future, we must not lose sight of the key concepts such as ensuring that all citizens maintain their right to health care, regardless of their individual ability to pay, and that when resources are scarce, the Government will fulfil its moral duty to distribute those resources in a fair and equitable manner. In this article I have pointed out that the FCC proposal places physicians in a position where they face a significant conflict of interest. They must choose how to allocate their time between all of their patients and, if the system were extended to encourage physicians to limit overall health spending, how to allocate access to hospital-based treatments as well. This would be a case of justice being determined at the bedside, which, although it does make clear the individual implications of justice decisions, brings with it very serious concerns about physicians' ability to limit their emotional involvement enough to make appropriate allocation decisions. Physicians would also be torn between functioning under a medical model, where individual rights are the top priority, or functioning under a public health model, where the health of their entire patient group should be the primary consideration. I have suggested that it is unfair of society to ask physicians to make these difficult decisions and to reward them financially for minimizing individual rights. How to allocate scarce resources remains a very difficult issue, but I have argued that the Government should not be allowed simply to pass this responsibility on to physicians. It is too much to ask of physicians and we as a society need much broader input into such important issues. The public is most affected by decisions that allocate health resources, but they are so far poorly informed about the likely implications of changing the way in which physicians are reimbursed for their services. In a system where members of the public finance health care and are the ultimate users of the services, we must find better ways to encourage their participation in reforms.

The allocation of health resources is likely to be an important question for the foreseeable future. Unfortunately, there is no easy answer, but more open discussion of the problems and potential solutions will help to develop a plan that meets with public approval. Other health professionals can and should enter into this debate. The current proposal of FCC in Alberta might help to control overall health costs, but bring with it a very heavy responsibility on physicians to make difficult decisions about who receives what medical services. FCC may be adopted as the way to reimburse physicians but, before that happens, we should encourage public debate to ensure that Albertans know what they are likely to receive.

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