

RESOLUTION 6 - 2010

Subject: Affirming the Need for Ethical Distribution of Health Care Resources
Introduced by: Joe Hippensteel, Tom Jeanne and Jon Strong
Referred to: Health Care Coverage and Access

1 Whereas, Health care spending in the state and nation is burgeoning;¹ and

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3 Whereas, Current Wisconsin Medical Society (Society) policy as outlined in HSR-003 ("Fee For
4 Service Plans in Health System Reform") states that the Society will support a plan for health care
5 reform that provides "universal access free from rationing;" and

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7 Whereas, De facto health care rationing currently exists due to unequal access to care and through the
8 influence of managed care organizations and insurance industry restrictions; and

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10 Whereas, Physicians must be qualified to make rational medical decisions balancing 'best' care and
11 cost-effectiveness;² therefore be it

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13 RESOLVED, That the Wisconsin Medical Society reaffirms that rationing necessary resources from
14 those that need those resources is unacceptable and unethical; and that some Wisconsin residents
15 today are unable to access necessary care, a condition that offends our ethical principles; and be it
16 further

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18 RESOLVED, That the Wisconsin Medical Society, in order to meet its three goals of health care
19 reform:

20 • Universal health insurance coverage

21 • High quality health care

22 • Control of health care costs

23 Affirms that ethical distribution of medical resources is a necessary component of a just health care
24 system, including a system of universal coverage, due to the existence of need that exceeds finite
25 resources; that Wisconsin physicians strive to provide health care commensurate with degree and
26 urgency of medical need rather than economic or other considerations; and be it further

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28 RESOLVED, That the Wisconsin Medical Society commit to review, through Councils on Ethics,
29 Access and Public Health, extant efforts and recommend for Wisconsin viable initiatives that assure
30 that all people receive the care they require, including beneficiaries of Medicaid, Medicare,
31 commercial insurance, and the uninsured.

Fiscal note: Within current budget.

References:

¹ Centers for Medicare & Medicaid Services. National Health Expenditure Fact Sheet. Updated February 3, 2010. http://www.cms.hhs.gov/NationalHealthExpendData/25_NHE_Fact_Sheet.asp. Retrieved Feb. 7, 2010.

² Ubel PA. Physicians, Thou Shalt Ration: The Necessary Role of Bedside Rationing in Controlling Healthcare Costs. *HealthcarePapers*, 2(2) 2001: 10-21.

Relevant Policies

Society:

ETH-005

Financial Incentives for Withholding Care: The Wisconsin Medical Society believes a physician's duty is to provide medically indicated evaluation and treatment. It is unethical to deny a medical service solely on the basis of cost containment, if such services are deemed good medical practice. (HOD, 0405)

HSR-003

Fee For Service Plans in Health System Reform: The Wisconsin Medical Society will support health system reform plans that:

1. Provide universal access free from rationing, and to include reasonable basic benefits, patient education, and significant patient responsibility for their own health care choices and behavior;
2. Are not biased toward managed care and include a true (fee-for-service) option, including balance billing;
3. Allow physicians and patients choice of plans and physicians;
4. Alleviate regulatory hassles and preserve high quality care;
5. Provide meaningful antitrust relief, including the ability for state and county medical associations to form partnerships of physicians for the purpose of being "accountable health plans;"
6. Provide true tort reform;
7. Provide significant insurance market reforms; and,
8. Recognize the physician's responsibility and authority in medical decision making and treatment in conjunction with the patient. (HOD, 0406)

HSR-012

Essential Elements and Guiding Principles for Health System Reform: The Wisconsin Medical Society (Society) endorses and reaffirms three essential goals in reforming the health care system:

1. Attain universal health insurance coverage.
2. Provide high quality health care.
3. Control health care costs.

The Society endorses the following guiding principles for health system reform:

- Retain a pluralistic health care system that promotes competition based on quality and cost.
- Expand insurance coverage through purchasing pools, premium subsidies and a "Play or Pay" model.
- Attain knowledge and understanding of health care delivery costs and information comparing various pricing systems.
- Foster consumer participation in costs and decisions regarding utilization of health care services in partnership with their physician.
- Protect existing "safety net" programs while seeking expanding eligibility as needed.
- Consider an explicit priority-setting process, based on evidence-based medicine and cost-effectiveness, for coverage of services by public and private insurance programs.
- Certify a state-defined standard benefits package, with any coverage beyond such a standard package to be treated as taxable compensation to the employee (in both private and public sector coverage).
- Promote adoption of practice guidelines and disease management protocols based on the best evidence available that will allow for appropriate flexibility in treating patients when measuring adherence to and variations from the guidelines.
- Promote payment levels by government-funded programs sufficient to eliminate cost shifting onto other payers, which results in price distortion and restricted access to services. (BOD, 0709)

AMA:

H-165.997 Prioritization of Health Care Services

(1) Our AMA urges the medical profession to develop and pursue an initiative for improvement in the systems design for medical and health care plans. (2) Our AMA opposes rationing of health and medical care services. (3) In developing its initiative to contribute responsibly to improvements in the systems design of health and medical care plans, our AMA urges the medical profession to support efforts to evaluate all mechanisms for financing, provision of care and reimbursement in light of their impact on access to care, quality of care and affordability. (4) Our AMA will develop additional clinically based criteria by which benefits desirable under both private and publicly funded health plans can be identified, and will use these criteria in further refining AMA policy in this area. (5) These criteria will be used to evaluate any benefit package developed by any source. (6) Our AMA continues to support the allocation of health services through a decentralized working of the market, coupled with incentives for effective individual choices, as the preferred alternative to centralized prioritization of services or decisions about coverage for such services. (7) Our AMA urges that physicians work to assist society, including legislatures, whenever discussion regarding prioritization of resources take place. (8) Our AMA will assist medical societies in those states considering or undertaking prioritization to develop processes and criteria for such prioritization that best serve the needs of patients. (9) Our AMA will study and take the lead in stimulating discussion among all concerned sectors of society about the implications of limited and limiting health care resources, current experimental programs for centralized allocation, and the processes and criteria to be used in any such allocation. (10) Our AMA will continue to assign a high priority to the problem of the medically uninsured and underinsured and continue working toward national consensus on providing access to adequate health care coverage for all Americans. (Res. 88, A-84; BOT Rep. EE, I-92; CLRPD Rep. 3 - I-94; Appended: Sub. Res. 109, I-98; Reaffirmed: Res. 808, I-02; Reaffirmed: CMS Rep. 5, A-04; Consolidated: CMS Rep. 7, I-05)

E-2.03 Allocation of Limited Medical Resources

A physician has a duty to do all that he or she can for the benefit of the individual patient. Policies for allocating limited resources have the potential to limit the ability of physicians to fulfill this obligation to patients. Physicians have a responsibility to participate and to contribute their professional expertise in order to safeguard the interests of patients in decisions made at the societal level regarding the allocation or rationing of health resources. Decisions regarding the allocation of limited medical resources among patients should consider only ethically appropriate criteria relating to medical need. These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. Non-medical criteria, such as ability to pay, age, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered. Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. When very substantial differences do not exist among potential recipients of treatment on the basis of the appropriate criteria defined above, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula. Decision-making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The treating physician must remain a patient advocate and therefore should not make allocation decisions. Patients denied access to resources have the right to be informed of the reasoning behind the decision. The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession. (I,VII) Issued March 1981; Updated June 1994 based on the report "Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients," adopted June 1993 (Archive of Internal Medicine 1995; 155: 29-40).