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RESOURCE ALLOCATION—THE LEGAL IMPLICATIONS

Beth Gaze

Problems of resource allocation in the many health systems throughout the world are increasingly urgent. Although some argue that the problem is not one of limited resources but of misallocation of resources that would be sufficient if properly used.¹ Most writers agree that there are insufficient resources available to meet demand, requiring action to allocate limited resources. Extensive debate among ethicists, economists, and policy-makers is devoted to determining effective, efficient and equitable methods of allocating limited resources in response to potentially unlimited demand.

This paper outlines the problem of resource allocation and examines a recent Australian case in light of the complex problems raised by the need to contain health care costs in a mixed public and private health care system. Legal tensions are created by the possibility that resource constraints may affect the physician's role in caring for the patient, with possible consequences in negligence.

I. FROM RESOURCE ALLOCATION TO RATIONING

The difficulties involved in allocating resources can be analyzed in terms of levels of decisionmaking. At the highest level there is the unequal global distribution of health resources among countries, which is beyond the scope of this paper. Within each country's health system, macro, meso and micro levels of allocation have been identified.² At the macro level, decisions are made about allocating public funds to competing areas such as education, health, and law enforcement. Within the health system and health institutions, decisions are made at the meso or middle level concerning funding allocation to geographical regions, to specific patient groups, and to fields of medicine and health care. At the micro level, decisions are made about the access of individual patients to particular services within the health system.

1. Arnold S. Relman, M.D., *Is Rationing Inevitable?*, 322 NEW ENG. J. MED. 1809, 1810 (1990); Joseph A. Califano, Jr., *Rationing Health Care: The Unnecessary Solution*, 140 U. PA. L. REV. 1525 (1992) ("Rationing is a macabre dance of despair . . .").

2. Ian Kennedy & Julie Stone, *Making Public Policy on Medical-Moral Issues*, in *ETHICS & LAW IN HEALTH CARE & RESEARCH* 81, 100 (Peter Byrne, ed., 1990).

The resources at stake include not only money used to provide services such as kidney dialysis, but also access to organs and tissues for transplants. With rising medical costs and shortages of organs and tissues, the criteria upon which allocation decisions are made are coming under increased scrutiny.

Although the macro and meso levels are readily identifiable as involving political decisions, the decisions on the micro level traditionally have been regarded as the area for clinical judgment by the skilled health care practitioner. Debates about allocation tend to fall into two categories. First there is a debate regarding criteria and methods for use in allocating resources at levels where no particular individual is directly affected. The recent attempt to prioritise health care services for the medically indigent in Oregon is an example.³ The second category of debate concerns cases affecting identifiable individuals: If resource limitations have to be taken into account in such cases, by whom should it be done, and how can the decision be made? Examples include the problem of selecting one of several needy patients to receive an organ available for transplant, or be admitted to an intensive care unit,⁴ as well as situations such as admission to a dialysis program, where giving treatment to the one present individual can deprive individuals who come along later but may be more "worthy" of treatment.

Resource allocations that directly affect the care of individual patients raise the most intractable problems of justice, law, and medical ethics. A decision that confronts the medical practitioner with a necessity to choose which patient will be entitled to limited resources can be viewed as a "rationing" of care. Where the patient's own doctor has to make such a decision, the traditional role of the physician is challenged. The doctor's duty to act in the best interests of his or her patient appears inconsistent with a requirement to consider resource limitations in recommending or providing access to health care services. Although the argument is often made that doctors must engage in this process if health costs are to be controlled, treatment of individuals nevertheless provides the worst possible context for resource allocation decisions.⁵

3. For descriptions of the organ plan see David C. Hadorn, *The Oregon Priority-setting Exercise: Quality of Life and Public Policy*, 21 HASTINGS CTR. REP. (May-June 1991) at 11, and Michael J. Garland, *Justice, Politics and Community: Expanding Access and Rationing Health Services in Oregon*, 20 LAW MEDICINE AND HEALTH CARE 67 (1992) (This article describes the Oregon Plan and its prioritization of health services). For criticisms, see generally David J. Rothman, *Rationing Life*, N. Y. REV. BOOKS (March 5, 1992) at 32, 26, and Sara Rosenbaum, *Mothers and Children Last: The Oregon Medicaid Experiment*, 18 AM. J. L. & MED. 97 (1992).

4. These are common examples used in ethical discussions of the problem. See, e.g., Lyn Gillam, *Resource Allocation: The Unavoidable Debate*, 11 BIOETHICS NEWS 49 (1992).

5. George J. Agich, *Rationing and Professional Autonomy*, 18 LAW, MED. & HEALTH

The two main tasks in the policy debate about health resource allocation are to describe, analyze and critique existing arrangements, and to make and justify proposals for future policy. If resources must be allocated under conditions of scarcity, then what methods of allocation are possible, and which are preferable? Justice as between individuals requires that decisions be based on fair evaluations of individual entitlement to scarce treatments. Agreement on the basis for such evaluations, who should make them, and on what criteria or on what theory of justice they should be made is elusive.

Rationing can be done implicitly or explicitly, formally or informally.⁶ In most cases, existing methods of rationing are implicit and informal: The most common example is waiting lists for services,⁷ onto which may be grafted criteria of medical urgency or need, or ability to benefit; and ability to pay, where higher levels of treatment are available to those who pay privately for their treatment or who buy health insurance. Although some elements of a market exist, the health system cannot operate on a market basis.⁸ The patient does not buy services directly, but through a doctor. The effect of health insurance is that the consumer is often not paying for health services, and there may be no incentive in the insurance scheme to minimize consumption of health resources. Instead, the incentives for both patient and doctor may be the reverse.⁹ Although cost-saving innovations such as health maintenance organizations and practice budgets have begun to make an appearance, the market cannot be the sole means of regulation of health service provision. Because most first world societies regard a minimum level of health care as a human right (albeit a welfare right not enforceable against the state¹⁰), some degree of equality in service provision is required.¹¹

CARE 77 (1990); Robert G. Lee & Frances H. Miller, *The Doctor's Changing Role in Allocating U.S. and British Medical Services*, 18 LAW, MED. & HEALTH CARE 69 (1990); Robert M. Veatch, Ph.D., *Physicians and Cost Containment: The Ethical Conflict*, 30 JURIMETRICS J. 461 (1990).

6. Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 U. PA. REV. 1573, 1573-4 (1992).

7. In Australia's public health system, "[w]aiting lists for surgery are widely used. Queue-jumping may occur when there is a changed level of urgency for the surgery, and for less worthy reasons." NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL, DISCUSSION PAPER ON ETHICS AND RESOURCE ALLOCATION IN HEALTH CARE 8 (1990).

8. Blank, *supra* note 6, at 1586-87.

9. "In traditional medical systems of fee for service, the more services the physician deems appropriate, the greater the physician's income. Under newer capitation reimbursements, if the physician determines what care can be eliminated, he or she may be tempted to undertreat." Veatch, *supra* note 5, at 467.

10. Australia is committed to the maintenance of health care as a human right through its signature of the International Covenant On Economic, Social And Cultural Rights, Article 12 of which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

Existing methods of allocating health care are often criticized as defective because of their informality, which leaves them open to inconsistency and abuse. In practice resources are often allocated implicitly by underfunding certain areas of operation, or by cutting staff members severely. It is frequently argued that, given that rationing must occur, explicit or formal rationing is preferable - that if people are not getting access to all possible health care, they should be made aware of it and the basis for it.¹² This leads to a debate about the ethical acceptability of various explicit or formal methods of allocation, and a search for some objective means of assessing entitlement to treatment. Should treatment be given to those most in medical need of it, or to those of most value to society, or on the basis of maximizing social utility? How are these characteristics to be objectively evaluated?¹³

Policies concerning resource allocation need to be developed systematically on the basis of adequate information, but the complexity and difficulty of this task cannot be underestimated. As has been said of health care expenditure planning, "[t]he issues involved are so complex, . . . that planning often degenerates into reactive responses to pressure."¹⁴ Even if any particular method could command broad social support, and even if criteria for evaluation could be identified and agreed on for example for calculating utility, based on maximizing benefit from treatment or evaluating the social worth of patients, or ranking social priorities across the diverse range of health services—there would still be the problem of implementing them consistently and fairly in a large and dispersed health system.

The Oregon priority-setting exercise¹⁵ is an attempt to develop a formal and explicit ranking of health care priorities in a situation of restricted resources. It can be seen as a beginning in the process of developing some sort of "objective" measure on which to comparatively evaluate the benefit of different types of health services to aid resource allocation.¹⁶ But it has been

11. Cf. Paul T. Menzel, *Some Ethical Costs of Rationing*, 20 *LAW MED. & HEALTH CARE* 57, 62-64 (1992) (rejecting "medical egalitarianism").

12. Frances H. Miller, *Denial of Health Care and Informed Consent in English and American Law*, 18 *AM. J. LAW & MED.* 37, 70-71 (1992).

13. Medical criteria such as need and ability to benefit may appear to be objective but are not necessarily so, as they cannot exclude reference to social characteristics of the individuals being assessed. Determination of social value of particular treatments or individuals is unavoidably subjective, and criticism of the Oregon exercise illustrates the difficulty of achieving social consensus on any ranking of needs. Although the concept of a QALY (quality adjusted life year), for example, is useful in argument, its practical implementation is fraught with difficulty.

14. Andrew Grubb & Ian Kennedy, *HIV and AIDS: Discrimination and the Challenge for Human Rights*, in *CHALLENGES IN MEDICAL CARE* 21 (Andrew Grubb, ed., 1991).

15. See *supra* note 3 and articles cited therein.

16. Hadorn, *supra* note 3, at 43 (describing the first attempt to operationalize the QALY).

criticized; it affects only the Medicaid part of Oregon's health care costs, by reducing services to some of those covered by Medicaid to broaden eligibility. Services are reduced only to those sections of the medically indigent without significant political influence.¹⁷

Even if these difficulties could be overcome, and even if some method of objectively evaluating and comparing the value of different treatments, or the value of treating different patients, gained widespread support, the problem of the impact of rationing on the doctor-patient relationship remains. The traditional understanding would have to be reconciled with a decision based partly on financial or economic criteria rather than "medical" criteria.¹⁸ David Mechanic, in his article, *Professional Judgment and the Rationing of Medical Care*, has argued that explicit rationing is likely to be insensitive to the complexity of clinical care, and that implicit rationing offers the most realistic and appropriate way to allocate services.¹⁹ But informal or implicit rationing may still be inconsistent with the doctor's duty to promote the best interests of the patient. Whether rationing be done explicitly or implicitly, its effects on the doctor patient relationship may have legal consequences if it undermines the physician's legal duty to the patient.

II. LAW AND RESOURCE ALLOCATION

Not only is law the major mechanism through which policy choices can be implemented, but it is also the forum in which the consequences of various methods of resource allocation must be resolved. To the extent that ad hoc allocations of resources already occur, however ethically or economically problematic,²⁰ the legal system already faces the practical consequences, especially in cases involving the treatment of individuals.

There are two main ways in which these issues can be raised in litigation. First, action can be brought directly seeking access to health care services which have not been made available to a patient. Alternatively, criminal or civil action, such as a negligence action, may be taken in respect of injury

17. Rosenbaum, *supra* note 3, at 107 (pointing out that the exclusion of aged and disabled Medicaid recipients from the reallocation mean that essentially it applies only to women and children. Priorities were determined by a wider social group than that affected).

18. Menzel, *supra* note 11, at 62-64 (arguing that decisionmaking which takes account of financial limitations can be consistent with the doctor's duty to the patient); Veatch, *supra* note 5, at 46 (arguing that it cannot).

19. David Mechanic, *Professional Judgment and the Rationing of Medical Care*, 140 U. PA. L. REV. 1713, 1727 (1992). See also Lee & Miller, *supra* note 5, at 71 (commenting that implicit rationing within the British National Health Service has been accepted by the public, but the move towards explicit rationing is more controversial); see also Miller, *supra* note 12, at 57-58.

20. Agich, *supra* note 5, at 77; Gillam, *supra* note 4, at 49.

suffered as a result of denial of access to particular services. Courts in the United States and England have encountered cases in both categories and have begun the process of developing a response. Frances Miller, in his article, *Denial of Health care and Informed Consent in English and American law* has examined the development of litigation in both jurisdictions both in administrative law and in tort.²¹ Cases in the former category have been largely unsuccessful with the exception of *Greater Washington, D.C. Area Council of Senior Citizens v. District of Columbia Government* in which a senior citizen's organization alleged that the District of Columbia government had failed to provide adequate treatment and facilities at District of Columbia General Hospital.²² In other American cases and in England, the courts have seen resource allocation as an administrative responsibility not to be interfered with unless manifestly unreasonable.²³ In the United States, the tort category primarily involves litigation against health insurers and not physicians; the courts have acknowledged that existing methods of limiting health services for some patients may result in liability. In English tort litigation, such liability has not developed, yet statements by judges in several cases suggests it may be possible in an appropriate case.²⁴ Australia has not yet seen much litigation on these issues.²⁵

III. RESOURCE ALLOCATION IN AUSTRALIA

In 1990 the Health Care Committee of the Australian National Health and Medical Research Council (NH&MRC) released a discussion paper on the Ethics of Resource Allocation.²⁶ The paper discussed an alternative to

21. Miller, *supra* note 12, at 46-52, 54-61. See also Mark A. Hall *The Malpractice Standard Under Health Care Cost Containment*, 17 LAW, MED. & HEALTH CARE 347 (1989).

22. *Greater Washington D.C. Area Council of Senior Citizens v D.C. Gov't*, 406 F. Supp. 768 (D.D.C. 1975). Miller also cites *Dallas Gay Alliance v Parkland Memorial Hosp.*, No. 88-6346-A (4th Dist. Dallas County, Tx., May 20, 1988) reprinted in GEORGE J. ANNAS et al., AMERICAN HEALTH LAW 313-14 (1990), in which a hospital was ordered to cease rationing care for HIV positive patients.

23. Miller, *supra* note 12, at 70-71 (discussing *R. v. Secretary of State for Social Serv.* in JOHN FINCH, HEALTH SERVICES LAW 37 (1981); *R. v. Secretary of State* (Queen's Bench), Nov. 24, 1987) (LEXIS, Intlaw library, UKCase file); *R. v. Secretary of State for Social Serv.*, (Court of Appeal, Jan. 6, 1988) (LEXIS, Intlaw library, UKCase file), and the American case of *Boone v Tate*, Civil No. 713 (C.P. Phila. County, Pa., Apr. 30, 1970), appeal dismissed as moot, 286 A.2d 26, 28 (1972), reprinted in ANNAS, *supra* note 22, at 415-417.

24. Miller, *supra* note 12, at 60-61.

25. John McPhee, *Some Legal Issues in Health Care Rationing*. Bioethics In The Wider Community at 173, (1991) (papers of the first National Conference of the Australian Bioethics Association).

26. NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL DISCUSSION PAPER ON RESOURCE ALLOCATION IN HEALTH CARE (1990) [hereinafter NH&MRC]. Reproduced in an appendix to the Discussion paper is a set of recommendations and checklists prepared by

searching for a positive set of priorities for allocation of care, using a set of questions proposed by Jennett of Glasgow, which asks whether care is unnecessary, unsuccessful, unsafe, unkind, or unwise.²⁷ The approach seeks to conserve health care resources by eliminating unnecessary and ineffective treatment.²⁸ The approach is an important one but alone cannot solve the problems of allocating limited resources. The issue of resource allocation has been referred to the Australian Health Ethics Committee²⁹ for further work.

The highest level of resource allocation in Australia is that undertaken by federal and state governments concerning distribution of funds among areas of government expenditure and within the health system on the basis of geographical distribution and area of operation. This level of decisionmaking is complicated by political and federal tensions in the relationships between the federal government and the states. In Australia's federal system, responsibility and control of health care is split between federal and state governments. The federal government, with the best sources of revenue from income and other taxes, funds the major part of health care expenditure, but does not have legislative power under the Australian Constitution to regulate directly medical practice or health service institutions.³⁰ It attempts, however, to regulate the health industry indirectly by attaching conditions to funding it provides to the states for hospitals, health centers, nursing homes, and to doctors and pharmacists for medical, pathology and pharmaceutical benefits.³¹

Medical care is provided on a fee-for-service basis whereby doctors may either charge patients directly, with patients then recovering a rebate from the tax-funded Medicare national medical care program, or "bulk bill" for

ALBERT WEALE, *COST AND CHOICE IN HEALTH CARE* (1988) which explore the basis on which resources are allocated at national, institutional and individual levels.

27. B. JENNETT, *HIGH TECHNOLOGY MEDICINE - BENEFITS AND BURDENS* (1986), quoted in NH&MRC, *supra* note 26, at 8-9.

28. "Neither medicine nor law has a usable or reliable methodology or set of principles in place to distinguish between needed and unnecessary care . . ." Edward B. Hirshfeld, *Should Ethical and Legal Standards for Physicians Be Changed to Accommodate New Models for Rationing Health Care?*, 140 U. PA. L. REV. 1809, 1816, 1828-31 (1992). See also Robert M. Veatch & Carol Mason Spicer, *Medically Futile Care: The Role of the Physician in Setting Limits*, 18 AM. J. LAW & MED. 15 (1992); Mark A. Hall & Gerard F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

29. The Australian Health Ethics Committee is a subcommittee of the National Health and Medical Research Committee and was formed in 1990 as the successor to the NH&MRC's Medical Research Ethics Committee and to the National Bioethics Consultative Committee.

30. The federal government's power to legislate in this field is limited to "the provision of . . . pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription) . . ." AUSTL. CONST. § 51(23a) (1900).

31. See generally National Health Act 1953 (Cth), Health Insurance Act 1973 (Cth).

services directly to Medicare. The Medicare rebate is set at 85% of the standard fee for services specified in the schedules to the Health Insurance Act 1973 (Cth), but the gap has widened as the fees charged by doctors have risen faster than the schedule fees. Private health insurance is strictly regulated by the Health Insurance Act 1973 and, as a cost control measure, is not permitted to cover non-inpatient medical fees including the gap between the fee charged and the Medicare rebate. Private health insurance is permitted to cover hospital costs. Public funding for public hospitals has not increased in proportion to the increasing costs of providing high technology services, which has led to lengthy waiting lists for uninsured patients seeking treatment in public hospitals, while insured patients can be treated without delay in either public or private hospitals. The states have legislative powers to regulate the medical profession, hospitals, and other health service providers and institutions, but due to their very limited sources of revenue, are largely dependant on the federal government for funding of all such institutions. Once the overall allocations of funding have been decided, allocations must be made within health care regions and institutions. Control can be exercised by state governments in this process to ensure that public priorities are served.³²

Litigation in Australia has just begun to explore the tensions caused by allocation of resources to different areas within this structure. Institutions and organizations involved in the health system use the legal system as an instrument in their contests, and try to establish and improve their positions through litigation. In recent years challenges have been made to decisions of the Pharmaceutical Benefits Review Tribunal which sets the level of pharmaceutical benefits for drugs supplied at public expense, which led ultimately to its abolition and the advent of the Pharmacy Restructuring Authority.³³ There has also been a challenge to attempts by the federal government to reduce pathology fees through amendments to the pathology fees schedule to the Health Insurance Act.³⁴ In these cases, government policies concerned with control of expenditure in areas of the health system where services are provided at public expense by private providers have been challenged and set aside on administrative law grounds. The legal errors involved can be quite technical, but the sums of money are significant. This

32. The states have full power to legislate, subject to conflicting federal legislation which prevails where state and federal laws conflict (AUSTL. ACTS P. CONSTITUTION, § 109). State laws regulating health services allow directions to be given by the Health Minister in relation to resource allocation. See e.g., Health Services Act 1988 (Vic.) § 42.

33. *Commonwealth v. Pharmacy Guild of Austl.*, 91 A.L.R. 65 (P.C. 1989) (Austl.); *Dornan v. Riordan*, 95 A.L.R. 451 (P.C. 1990) (Austl.).

34. *Queensland Med. Lab. v. Blewett*, 84 A. L. R. 615 (P.C. 1988) (Austl.).

area of litigation seems to be expanding as tension over the costs of the health system increases and the government attempts to rein in the level of public funding available to private sector participants in the health system.

Litigation concerning individual patients affected by resource allocation decisions is still very rare. *Pullinger v. Medical Benefits Fund*³⁵ is the only clear example of such litigation. It concerned the limit on both public and private subsidies for long term patients in hospitals when less expensive nursing home accommodation would be sufficient for the patient. This policy was implemented by section 3B of the Health Insurance Act 1973 (Cth) which provided that after thirty-five days as a hospital inpatient, the benefits payable by a private health insurance fund fall back to a low level (which is not adequate to cover hospital care) unless a treating doctor signs an "acute care certificate" stating that the patient is in need of acute care and is not a "nursing-home type" patient. The statute merely specifies the rule, and does not state the policy basis for the provision, nor clarify the criteria for assessing the need for acute care. This gives very little guidance to a doctor applying, or a court interpreting the rule.

In *Pullinger*, Karen Pullinger was an eight-year-old girl born with severe intellectual and physical disabilities. Her condition, Smith-Lemli-Opitz syndrome involved cerebral palsy, cortical blindness, epilepsy, and severe nutritional problems, as well as susceptibility to infection, and a tendency for her limbs to stiffen and shrink, requiring frequent physiotherapy, and special chairs, and splints. Her outlook was for "inexorable deterioration and early death."³⁶ She was an inpatient in a private New South Wales hospital, and had been for more than thirty-five days. The cost of her accommodation was being met by the private health insurance fund of which her parents were members, Medical Benefits Fund (MBF). A doctor had signed the certificate stating that she needed acute care, within the meaning of section 3B of the Health Insurance Act. A place in a public children's hospital was available, but it was not able to provide the level of physiotherapy and other services that she was receiving in the private hospital.

The underlying resource allocation issue was whether such a patient, who had no prospect of improvement, could continue to receive more intensive and expensive treatment in the private hospital, or whether only care in the public hospital would be provided. The mechanism by which this issue was to be determined was the legal issue of whether she was in need of "acute care." Pullinger's acute care certificate was reviewed by an Acute Care Advisory Committee under the Health Insurance Act, which decided that the

35. 95 A.L.R. 463 (P.C. 1990) (Austl.).

36. *Id.* at 464.

certificate had been wrongly issued, thus removing the liability of MBF to reimburse her parents for hospital accommodation and making it financially necessary to move her from the hospital in which she was accommodated to another institution. In essence, the Committee said that acute care could only be justified where there was hope of improvement in a patient's condition.

Pullinger's parents challenged this decision in the Federal Court, arguing that the Acute Care Advisory Committee had wrongly interpreted the statutory requirement that the patient be "in need of acute care" for the certificate to be issued. All three judges of the Full Court of the Federal Court held that the Committee had made an error of interpretation which justified setting its decision aside. A possibility of improvement in a patient's condition was not an essential requirement for justifying acute care; avoiding further deterioration would also be sufficient. The reasoning of the judges varied, but all approached the case on the basis that their task was solely to determine the correct meaning of the words of the statute. They did not examine the policy which Parliament intended to implement when it passed this particular provision.

The limitation on private insurance for long term hospital stays which were not medically necessary was designed to reduce costs by ensuring that patients for whom nursing home levels of care was adequate could not remain in hospitals.³⁷ This is clearly an important element of government policy of cost control in health service institutions, but the test expressed in the legislation was vague and left it apparently a question of medical judgment. Because so little direction was given, it would have been very difficult for the court to try to give effect to the policy even if it had been willing to do so.

Whether a patient needs to continue in a hospital bed or can receive adequate care in a nursing home can only be answered by someone with medical expertise. Where the answer is borderline, there is little incentive for a private hospital doctor to refuse her or his patient a certificate. It seems likely that the doctor and the Acute Care Advisory Committee applied different understandings of the need for acute care but this seems unavoidable when no standard was expressed in the legislative test. Had the statute given a better indication of the criteria on which such a decision could be based, the court may have been better able to consider how to give effect to the policy.

One lesson from the case is that policies of resource restriction which affect individuals need to be clearly stated in legislation before they will be applied by courts to give effect to the policy. The case is also of interest for what the statutory test required of the doctor issuing the certificate. If the

37. *Id.* at 464, 469.

doctor was required to economize by restricting patient care on economic grounds beyond what was medically necessary, it would distort the doctor's clinical discretion. Given that such an interpretation was not clearly mandated by the statute, the only correct way for Karen Pullinger's doctor to interpret the test for eligibility to remain in a hospital bed was to consider only her interests and to decide whether she could continue to gain any benefit at all from remaining there. Any other course could have amounted to a breach of the standard of care required of the medical practitioner.

IV. THE DOCTOR'S CLINICAL DISCRETION

When it is suggested that the doctor should take responsibility for rationing scarce or expensive health services like hospital beds, little attention is given to exactly how it can be done. Doctors are neither trained to undertake such allocation decisions, nor specifically directed as to what sorts of criteria and considerations are legitimate or illegitimate. Indeed, it is contrary to their training, which is to act in the best interests of their patients. When political will fails at other levels of the health system, and setting guidelines turns out to be too difficult, the hard decisions are left to doctors in their individual treatment decisions with virtually no guidance. It is difficult to see how individual practitioners can allocate resources on a legally defensible and ethically acceptable basis in these circumstances. The likely result is informal rationing on the basis of unstated criteria.

V. NEGLIGENCE AND RESOURCE ALLOCATION

Where a medical practitioner takes account of resource limitations in treating a patient, a risk of tort liability may arise. If the patient can show that damage was suffered as a result of the decision, then it will be scrutinised to see whether or not the requisite standard of care was met. Can, or should, resource limitations affect the standard of reasonable care?

This issue could arise in situations at all levels of the health system. At the macro level, would provision of different standards of health care in different geographical areas, or different areas of practice be legally acceptable? At the institutional level, understaffing, for example of an intensive care unit, or failure to provide a new and beneficial drug to patients because of its expense,³⁸ are potential problems. For the individual practitioner, variations

38. In Australia, refusal by the Federal government to approve a drug for federal funding within the pharmaceutical benefits scheme may severely restrict its accessibility if it is expensive: Danielle Talbot, *Complaint On Cancer Drug Funding*, AGE Nov. 2, 1992, at 5 (refusing to list cancer drug G-CSF); *Doctors hit out at Decision on Cancer Drug*, AGE June 23, 1992, at 15 (refusing to list cancer drug Neupogen because it wanted use limited to major public hospitals).

in practice, for example in treatments accepted as standard by the profession, or in selecting patients for treatment such as dialysis could be problematic, as well as limitations on treatments undertaken.

Prima facie, resource limitations would not provide an excuse for a breach of duty.³⁹ Standards of care are assessed in the context of each case through expert testimony. In the particular case the restriction of resources may be a given, so that it is merely an underpinning factor in setting the standard.⁴⁰ This is less likely where the negligence alleged was in carrying out a treatment, but more likely where limited resources preclude a beneficial treatment which would be otherwise available. Thus, if the expertise and equipment available were limited, then the assessment of care given will be made in the context of what was available; whether negligence could be found for failing to provide more expertise or better equipment is another question.

Are geographical or regional variations in care provided acceptable in a public health system? In litigation courts do not engage in an assessment of comparative levels of care in different institutions or different fields of medicine. Regional variations in levels of equipment and expertise may come to notice through expert evidence when the standard of care is being established. The extent to which this could amount to negligence is unclear and would probably depend by whom and on what basis services are provided, and the terms of the relevant legislation.⁴¹ In general, however, the legal system determines the standard of care only in the circumstances of the particular case, and not by looking at other standards in the system, or the system as a whole. Although an approach which permits considerable regional variations in the standard of care provided depending on the availability of medical technology and expertise (resources) is not desirable from the perspective of equity in health care, it may be unavoidable in expensive areas of care in which resources cannot provide for the whole system.

Where the standard of care given to patients or residents in health care institutions suffers as a result of understaffing, legal disputes can arise. Although malpractice cases in both England and the United States can be traced to pressures arising from restricted resources,⁴² there have been no reported cases of negligence on this basis in Australia. A coroner's inquest

39. McPhee, *supra* note 25, at 180-82; Miller, *supra* note 12, at 69-71; Hirshfeld, *supra* note 28, at 1831-42.

40. John A. Siciliano, *Wealth, Equity and the Unitary Medical Malpractice Standard*, 77 VA. L. REV. 439 (1991); Hirshfeld, *supra* note 28, at 1841-42; Miller, *supra* note 12, at 69-71.

41. See the discussion of Hincks' case *R. v. Secretary of State for Social Serv.*, 123 So. Jo. 436 (1979) in MASON & MCCALL-SMITH, *LAW & MEDICAL ETHICS* 259 (3d ed. 1991).

42. Miller, *supra* note 12, at 69-71; Hirshfeld, *supra* note 28, at 1841-42.

concerning a patient who died in a nursing home may serve to illustrate some of the problems.⁴³ The patient drowned in the bath after being left unattended. The nursing home was understaffed: It was required to operate with three general nurses on staff, but had only two. The Coroner found that it was common practice for more senior nurses at the home to leave patients unattended in the bath, and that during the preceding year many staff had left the home complaining of excessive workloads and inadequate provisions for patient care. Despite these findings, the Coroner exonerated the management of the home from responsibility for the death and found only the nurse on duty had contributed to the patient's death by failing to act in accordance with her training not to leave a patient unattended in the bath. The Coroner commented that there was no logical link between good nursing practice and failure to meet staffing levels.

The report does not tell us what other task the nurse was engaged in at the time the patient was left unattended, so it cannot be concluded that the understaffing was the cause of her inability to meet the professional standard of care. The Coroner was unwilling to adjust the law's expectation of the standard of care which a trained nurse should provide. It is likely that a similar approach would be taken in a negligence action. This could place the individual health practitioner at risk for understaffing over which he or she has no control. If understaffing leads to harm, then who should be responsible?

This issue was raised in the context of a disciplinary action against two nurses in the Canadian case of *Mt Sinai Hospital v. Ontario Nurses Association*.⁴⁴ Six nurses were on duty in the intensive care unit (ICU) at the hospital, four of whom were trained intensive care nurses and two of whom were relief nurses, who had either no experience or no recent experience in ventilating patients. There were eight patients in the ICU of whom five required ventilating. The nurses said it was the busiest night they had experienced and that there had been no time for any lunch or tea breaks. Another patient was referred to the ICU for ventilation following respiratory arrest, and the senior medical registrar decided to admit him to the ICU. The nurses said they were unable to accept him because of their workload and informed the nursing supervisor of this. She said they "should cope" and "do the best you can". The nurses refused to provide care and the patient was cared for

43. Andrew Bock, *Nurse contributed to Man's Death after Bath: Coroner*, AGE, May 9, 1992.

44. See Amelda Langslow, *Legal Issues: An Over-view of a Case Study 61 in THE ROLE OF THE NURSE: DOCTOR'S HANDMAIDEN, PATIENTS' ADVOCATE OR WHAT?, CONFERENCE PROCEEDINGS, CENTRE FOR HUMAN BIOETHICS, Monash University (1987)*, at 67-69, citing Corinne Skier, *Sinners or Saints? The Legal Perspective*, 75 *The Canadian Nurse* (Nov/Dec. 1979).

in the ICU by three members of the medical team. The consequence was that the hospital viewed the nurses' actions as insubordination and docked them three days pay.

An appeal by the nurses to an arbitration panel upheld the penalty by two to one. The majority laid emphasis on the need for the hospital to be able to insist on orders being carried out, and the fact that nurses did not have superior knowledge to the medical staff on the overall needs of all the patients. The dissenting member regarded the hospital management as responsible for putting the nurses into such an intolerable situation, and would not have penalized the nurses for their actions. What should the staff have done in such a situation? If the extra patient had been admitted and he or another patient had suffered because they received inadequate nursing attention, would (and should) the nurses in the Mt. Sinai Hospital have been held liable for negligence, or disciplined? This might depend on whether the understaffing situation could be a defence available to the nurse, but not the institution.

VI. THE LIABILITY OF THE HOSPITAL

Could the hospital be liable for negligence in understaffing even though its staff were not individually negligent? In cases concerned with whether care actually given was of an adequate standard, the courts have held that the duty of a hospital to its patients may go beyond merely engaging competent and careful staff to treat patients. The hospital itself, and not just the treating doctor or nurse, may come under a duty to ensure that treatment is given with adequate care. This is referred to as a hospital's "non-delegable duty" to its patients; it makes the hospital primarily, and not merely vicariously liable for negligence within it.⁴⁵ Where it applies, then appointing competent staff will not fully discharge the hospital's duty of care. Such a formulation leaves open an avenue by which the concept of negligence can be used to analyze a broader situation than merely the competence of the actual care given to or by a specific individual. It is possible that understaffing which leads to errors in care or treatment could be taken into account by this means. Would it also extend to unavailability of treatments due to resource limitations?

Whether a non-delegable duty of care applies depends on the facts of each case.⁴⁶ Where a private doctor has been retained by the patient, it is unlikely

45. William P. Whippy, *A Hospital's Personal and Non-Delegable Duty to Care for Its Patients - Novel Doctrine or Vicarious Liability Disguised?*, 63 AUSTL. L. J. 182 (1989); *Ellis v. Wallsend District Hospital*, 17 N.S.W.L.R. 553 (Ct. App., N. S. W. 1989); cf. *Hirshfeld*, *supra* note 28.

46. Whippy, *supra* note 45, at 198-201.

that the hospital will be held to have a non-delegable duty of care in relation to the treatment given by that doctor. But where staff doctors provide treatment, whether they are employees or honorary consultants, then the non-delegable duty may be applied to hold the hospital primarily liable for breaches of the required standard of care. Despite the possibilities opened up by this analysis, no negligence claims concerning understaffing have been reported in Australia. This may be because it never occurs, or it may be because such cases are settled rather than litigated in the absence of a good defence.

The argument that limited resources or understaffing are the reasons for failure to meet the standard of reasonable care creates a dilemma for the courts. In the interests of patients, these cannot be sanctioned as a basis for reducing levels of care; but the alternative is to maintain standards of care for fewer patients.⁴⁷ The courts are not qualified or empowered to make this choice, and in Australia judges are reluctant to take a position which could suggest to the executive or administrators where money must be spent. The decision is one of policy for the health and hospital authorities to make, but the Coroner's case mentioned above suggests that the courts will also be reluctant to accept excuses for inadequate care, or financial stringency as a reason for reducing standards of adequate care in institutions.

Cases brought directly to try to force expenditure on health care in England and United States have generally not been successful.⁴⁸ In England, a group of patients in an orthopaedic hospital brought an action complaining of unreasonable delay in their treatment, because of a shortage of facilities arising in part from a decision not to build a new block of the hospital on the grounds of cost.⁴⁹ The judge dismissed their complaint, saying that it was not the court's function to direct Parliament what funds to make available to the Health Service and how to allocate them. If the courts are reluctant to do this directly in litigation it is unlikely they will be prepared to do the same thing indirectly through negligence actions.

Courts see the protection of the legal rights of individuals as the most important of their functions. They are unlikely to permit reductions in the rights of the individual patient to reasonably careful treatment unless clearly required by law, for example by legislation. It is unlikely that Australian courts will sanction a reduction in the common law duty of care accorded to

47. Kennedy & Stone, *supra* note 2, at 97-101 (discussing this problem in the context of two English cases concerning allegedly negligent obstetric care). These cases are also discussed by Miller, *supra* note 12, at 58-60.

48. See *supra* notes 21-23 and accompanying text.

49. *R. v. Secretary of State for Social Services*, in JOHN FINCH, *HEALTH SERVICES LAW*, 37 (1981).

patients in the interests of economizing. The danger, however, is that this may happen without courts recognizing it because they may not question the basis of clinical decision-making or the context closely enough to detect it.⁵⁰

Pressure for cost-reduction will continue, so a way must be found to reduce expense without risking negligence litigation. This could be done by legislation, but an alternative method which is open to the health care professions themselves is the development of guidelines which specify best practice standards in particular areas of concern. Once developed, the guidelines could be given legislative backing, as has occurred in Maine, where adherence to guidelines protects against malpractice claims.⁵¹ But even if legislative backing is not provided, guidelines developed by the professional group which command widespread support will be very influential in determining the standard of care. Although Australian courts have said, like English and American courts,⁵² that the standard of care is a question of law and not of professional practice, in areas of technical complexity the courts can only rely on expert professional evidence to determine whether or not care was reasonable in any particular context, and a reasonable, broadly supported professional view is unlikely to be rejected.

VII. CONCLUSION

In a system involving fee for service health care and private health insurance, service providers have little incentive to limit use of health care services, and health insurers find it easier to raise premiums than to seriously attempt to control the costs of health care to keep premiums down. Health consumers do not have enough information to take steps towards cost control. The Health Issues Centre recently commented that:

one of the principle objectives of health care providers is to increase the available resources to their sector [while] one of the principal objectives of governments is to constrain the availability of resources to a sector and distribute resources fairly within it. Conflict over resource allocation and the growth of costs which is unresolved tends to result in the costs of care being transferred to individual consumers, as a way of defusing the tensions between

50. English and Australian courts are concerned to avoid the path towards US style malpractice laws, partly to avoid the costs of defensive medicine: *Sideway v. Board of Governors of the Bethlem Royal Hospital* A.C. 871 (P.C. 1985); *Rogers v. Whitaker*, 109 A. L. R. 625 (H.C. 1992) (Austl.).

51. Califano, *supra* note 1, at 1533.

52. In Australia, *Roger* 109 A. L. R. at 625; *F. v R.*, 33 S. A. S. R., 189, 194 per King C. J. (1983). In the United States, *Helling v. Carey*, 519 P. 2d. 981 (Wash. 1974).

fundlers and providers.⁵³

Although debate thrives on how resources *should* be allocated, it is not clear how, even if a consensus could be achieved, the results could be implemented in a system where responsibilities are split in so many ways, and much effort is devoted to shifting the problems rather than resolving them. A lot of work will be needed before an acceptable explicit method of rationing health resources in cases affecting individuals can be achieved. It is to be hoped that the Australian Health Ethics Committee can make a valuable contribution when it reports on its work on this vast topic.

In the meantime existing allocations and existing methods of rationing care, by waiting and ability to pay will continue. This is not an area where it is desirable for courts to formulate policy, as they do not have the necessary knowledge, expertise or overview of the system. But unless steps are taken to continue the development of debate and policy in the area, it is likely that more and more of the issues surrounding resource allocation will come up for resolution before the courts, and the resulting decisions may not facilitate the changes which are needed in the health care system. It would be far better for guidance to be provided in advance to avoid disputes and create a consistent system of administration in health care.

53. HEALTH ISSUES CENTRE (VICTORIA), WHO CONTROLS WHERE THE HEALTH DOLLAR GOES?, 43 (Oct. 1991).

