Monographs of
the Víctor Grífols 18
i Lucas Foundation

FUNDACIÓ
VÍCTOR
GRÍFOLS
i LUCAS

3999/1
04/01/10

18

Waiting lists: can we improve them?

Waiting lists: can we improve them?

Monographs of
the Víctor Grífols 18
i Lucas Foundation

FUNDACIÓ
VÍCTOR
GRÍFOLS
i LUCAS

ISBN 978-84-692-0819-9
Edita: Fundació Víctor Grífols i Lucas. c/ Jesús i Maria, 6 - 08022 Barcelona
fundacio.grifols@grifols.com www.fundaciogrifols.org

Waiting lists: can we improve them?

Monographs of
the Víctor Grífols
i Lucas Foundation
18

CONTENTS

PRESENTATION

Health waiting lists constitute one of the most visible challenges faced by any public health system, and are the cause of more complaints than any other issue. Waiting lists are clearly an inevitable feature of any health service, given the fact that the resources available, however much they increase, will always remain limited. But the problem which concerns us more than any other with respect to waiting lists is of an ethical nature and relates to distributive justice and inequalities or discrimination between patients. While it is true that our health has improved noticeably as a result both of scientific and technical advances and the provision of a universal, public health system, the differences between those who have more and those who have less persist. Some have to wait for longer than others before receiving treatment, and this means that not everyone has the same opportunities, despite the theoretically universal nature of health protection. This fact makes it clear that there are problems which must be addressed if we are to maintain a system which is not just efficient and sustainable but also morally irreproachable. The seminar organized by the Víctor Grifols i Lucas Foundation and reproduced here, was dedicated to analyzing these problems and identifying some measures to address them.

Marisol Rodríguez's presentation analysed the issue from the perspective of health economics. She took as her starting point an empirical study of which she is the co-author, which exposes the inequalities which exist with regard to access to the health system. Using empirical data collected for the study, she asked what degree of responsibility can be attributed to the system and those who manage it, and how far such inequalities can be explained by the poor skills or knowledge of particular service users. Lack of information, being an immigrant or a foreigner in one's country of residence, or the lack of essential cultural understanding are all elements which can prevent or discourage people from using public services. Another interesting question to consider is the degree to which the inevitable prioritization of patients always ends up prejudicing the most vulnerable. From her analysis of all these issues she concluded that we must improve our management of waiting lists and implement measures to ensure that it is not always the most vulnerable who end up receiving the poorest care.

As a philosopher, Àngel Puyol asked whether we should give priority to certain services and specific patients when resources are scarce, and took as his starting point the hypothesis that efficiency and morality are not equivalent concepts. A system may be highly efficient yet lack ethical principals which guide how people act. Puyol considered what is the best way of prioritizing, and based his response on a detailed and exhaustive analysis of a wide range of criteria which are generally used when reaching decisions about the distribution of health services. He also analyzed these criteria from an ethical perspective, identifying the pros and cons of each and going beyond a strictly clinical or economic perspective to incorporate an ethical or moral viewpoint. While identifying the best criterion is impossible, we can strive for greater transparency which makes clear which criterion has been adopted in each case. However difficult or uncomfortable this may be, it is an essential element of treating patients with respect.

The two presentations were followed by a panel discussion which explored various aspects –political, clinical and psychological– of the problem of waiting lists, and this discussion is summarized here. Our intention in publishing this monograph is to help those who are interested in the issue of waiting lists and who also recognize that this is a question which, above all concerns the equity of the health system and which therefore poses a threat to any guarantee of the universal right to health coverage.

Victoria Camps
President

Health inequalities, prioritization and waiting lists

Marisol Rodríguez
Professor of Health Economics
at the University of Barcelona

Introduction

This study considers the relationship between waiting lists and social inequalities in health, from an economic perspective. The common ground is a concern for justice. In economics, this concept is addressed by the theory of distributive justice. That is, of how a society or group should allocate or share out scarce goods between different individuals with different needs or different claims. This allocation gives rise to ethical controversies which, in the case of waiting lists, are very clear. The ethical perspective of economics is a social perspective, where disputes are seen as a matter of priorities between groups of individuals or between one individual and another. This perspective differs somewhat from the usual approach in bioethics, which focuses primarily on the issue of what can and cannot be done to individual human beings, or on how far medicine and experimentation should go.

The question which concerns us here is to what degree waiting lists can be a source of, or can aggravate, social inequalities in health. It is, therefore, not simply a question of confirming that some individuals wait for longer than others before receiving a given treatment, but also of knowing whether it is the most disadvantaged members of society who wait longest, and whether this has consequences for social inequalities in health. Following Sen, we define this as a violation of the right of all individuals to have the same opportunity to achieve their full health potential[1]. It is societies –and their health systems– which have to guarantee this right.

The next section of my paper is based primarily on the book which I published, together with Rosa Mª Urbanos, on the issue of health inequalities, and reviews the existing evidence and summarizes the key facts. In section three, I address the question of the degree to which health systems are responsible, at least in part, for social health inequalities, as a result of their own inequity and differential treatment of individuals for reasons which go beyond that which is strictly necessary. These second and third sections prepare the ground for the fourth and final section in which we address the central issue of the presentation: the question of whether the use of waiting lists to prioritize patients leads – even involuntarily – to an unequal treatment which prejudices the socioeconomically disadvantaged.

Social inequalities in health

From the perspective of equity, one of the most worrying phenomena within the health sector is the continued presence of social inequalities in health. No matter which indicator of socioeconomic status we choose, or which criterion we use to measure health, in every case individuals in lower socioeconomic strata tend to have poorer health than those higher up the social scale. Furthermore, these differences are not only found between groups at either end of the scale, but also exist between adjacent groups. This phenomenon, where each social stratum has a slightly lower level of health than the one immediately above it in the hierarchy, and a slightly higher level than the one immediately below it, is known as the «social gradient» in health. Of course, this phenomenon is not new, and most of the available historical data points to the existence of such differences. However, the study of socioeconomic differences in health became increasingly important during the final quarter of the 20th century. This is due, among other reasons, to heightened social sensibility towards this state of affairs, and also to the fact that the persistence of such inequalities has frustrated some of the expectations placed upon the universal health systems created in developed countries after the Second World War.

The persistence of such inequalities is not incompatible with the fact that mortality has decreased and health has improved in all socioeconomic groups. However, the differences have remained –or have even increased– at least in relative terms[2]. The evidence for this is overwhelming. Table 1, for example, shows the ratio of mortality rates and differences in mortality rates

---

[1] Sen, A. «Why health equity?», *Health Economics* 2002; 11(8):659-666.

[2] Regidor, E. «Desigualdades socioeconómicas en la exposición al riesgo y en salud». In Rodríguez, M. and Urbanos, R. *Desigualdades sociales en salud. Factores determinantes y elementos para la acción*, Elsevier-Masson, Barcelona, 2008.

according to the level of education for individuals over 45 years of age in different European populations. Both the ratio and the simple differences in rates indicate a considerable degree of inequality which is, incidentally, greater in men than in women.

Table 1

Ratio and differences in mortality rates per 100,000 inhabitants, between individuals with a low level of education and subjects with a high level[a] in various European populations. Total mortality in subjects aged 45 years and over. First half of the 1990s.

	MEN		WOMEN	
Populations	Ratio of mortality rates	Difference in mortality rates per 100,000 inhabitants	Ratio of mortality rates	Difference in mortality rates per 100,000 inhabitants
Finland	1.33	1005	1.24	542
Norway	1.36	947	1.27	520
England and Wales	1.35	1052	1.22	435
Belgium	1.34	1020	1.29	577
Austria	1.43	1007	1.32	545
Switzerland	1.33	737	1.27	401
Turin	1.22	581	1.20	378
Barcelona/Madrid	1.24	540	1.27	311

a. The group with a low level of education includes those who had not completed primary education, those completing primary education, and those completing the first cycle of secondary education. Advanced studies included the second cycle of secondary education, post-secondary studies and university studies.

Source: Regidor, E. 2008, taken from Huisman et al. «Socioeconomic inequalities in mortality among elderly people in 11 European populations», *J. of Epidemiology and Community Health*, 2004, 58:468475.

The widening of inequalities is even clearer if we look at the data in Table 2, which compares the relative risk of mortality from ischaemic heart disease in men aged between 25 and 64 in Spain and France in 1980 and 1990, classified by occupational category. Not only have the differences become wider, it should be noted that they have actually inverted. While in 1980 the category of professionals and managers had the greatest risk of ischaemic heart disease (attributable, allegedly, to «executive stress»), in 1990 all the other occupational categories, including agricultural workers, had a higher relative risk.

Table 2

Relative risk of mortality from ischaemic heart disease by social class based on occupation in men aged between 25 and 64.

	SPAIN		FRANCE	
Occupation	1980	1990	1980	1990
Professionals and managers	1.00	1.00	1.00	1.00
Service staff	0.80	1.10	0.63	1.47
Agricultural workers	0.57	1.85	0.50	1.92
Manual workers	0.83	1.87	0.68	1.74

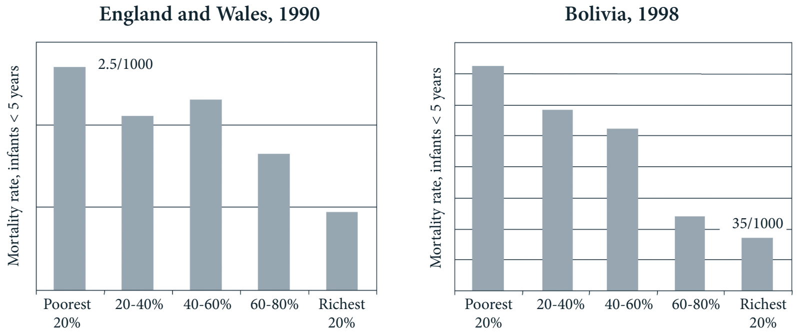
a.The relative risk expresses the mortality rate for each occupational category compared to the mortality rate for professionals and managers. In 1980 all the other occupational categories had lower mortality rates than professionals and managers, while in 1990 the opposite was true.

Source: Regidor, E, 2008, taken from Lostao et al. «Social inequalities in ischaemic heart and cerebrovascular disease mortality: Spain and France 1980-82 and 1988-90», *Social Science and Medicine* 2001; 52:1879-87.

Figure 1 illustrates another of the salient features of health inequality, which is that inequalities exist both *between* countries, and also *within* them, whether they are rich or poor. As the chart shows, children younger than 5 born in families in the poorest 20% of the population in England and Wales have a mortality rate which is approximately three times higher than that of children in families in the richest quintile of the population. In the case of Bolivia, the relative difference is fairly similar: almost four times higher. However, the mortality rate of the poorest 20% in England and Wales is 2.5 per thousand, while in Bolivia the mortality rate for the richest children is 35 per thousand!

Figure 1

Mortality rate in children aged younger than 5 in England and Wales, 1990 and Bolivia, 1998, according to family income quintile. Rates on different scales.



In summary:

- The general reduction in mortality and the improvement in health during the 20th century has not been accompanied by a reduction in socioeconomic inequalities in health.
- The inequalities display a social gradient which does not disappear, even when general socioeconomic levels improve and material conditions are not in themselves particularly harsh. Furthermore, these inequalities exist both *between* rich and poor countries, and *within* both rich and poor countries.
- The inequalities are large, whatever health indicator or indicator of socioeconomic condition is used to measure them. However, the patterns are not the same. In some countries inequalities in mortality are greater, in others inequalities in perceived health are greater, and in others inequalities in risk factors (smoking, obesity, etc.) are greater, and this makes it difficult to generalize.
- Inequalities almost always operate to the disadvantage of the poorest (although there have been periods when, for example, ischaemic heart disease or lung cancer affected the rich more).

- Inequalities do not follow the same pattern for men as for women.
- Inequalities appear to be growing rather than shrinking.
- The widely confirmed existence of socioeconomic inequalities in health makes it clear that there is a *sociological aetiology of health and illness*, above and beyond biological factors and medical care. However, the mechanisms through which these social differences are transformed into health differences are not yet sufficiently understood.
- Finally, it should be noted that the fact that these inequalities are greater in some countries than in others means that these are not immutable, and that there is room for manoeuvre in the form of political measures to correct these inequalities.

Are health systems responsible for health inequalities?

One of the motives for the creation of universal, public health systems in the majority of European countries was to achieve greater equality in health. It was hoped that free, unrestricted access to medical services would eliminate some of the differences in health which had been observed between the social classes. However, the publication of the Black Report in the United Kingdom in 1980 made depressing reading. The conclusions of this report had a devastating impact on British society; despite over 30 years of the National Health Service (NHS), the health differences between social classes defined by occupation had grown instead of shrinking. Specifically, «the probability of dying before retirement for lower class men and women (unskilled workers) was double that of the most advantaged social class (professionals and managers).» More worrying still was the fact that the differences appeared to have grown compared to the 1950s, above all for men of working age.

The Black Report had a major impact across the world, and generated a great deal of interest in studying to what degree health systems were fair or not, and to what degree they were partly responsible for the health inequalities identified. The criterion of equity which a public health system must meet is to provide «equal treatment for equal needs», irrespective of an individual's capacity to pay or any other personal characteristics.

If we are to check this empirically we must first find a way of making this equity criterion operational. In many of the numerous studies which have been carried out, «treatment» is normally taken to mean «use» or «effective consumption» or «health expenditure absorbed». And «need» is measured using a concept of standardized need, or expected consumption, that is, it is measured by calculating the quantity of health services an individual would have received if he or she had received the same treatment, on average, as other individuals with the same need characteristics: morbidity, perceived health, age and gender.

The results of the exhaustive research identify different patterns of health service use by different socioeconomic groups. In their summary, Rosa Mª Urbanos and Ricard Meneu[3] distinguish between «macro» studies which analyze the health system in general, and «micro» studies, focused on specific procedures or illnesses. The former tend to reveal a high degree of equity at least in European countries, including Spain, although there is a degree of «poor-biased» inequity in visits to general practitioners (which means that individuals with lower income make more use of this type of service than *what they would be entitled to* on the basis of their needs) and a degree of «rich-biased» inequity in visits to specialists. The use of hospital services matches need in almost all the studies.

The snapshot provided by the «micro» studies, however, is not so reassuring, as these show significant «rich-biased» inequalities in, for example, hip replacements, revascularization or heart catheterization after a heart attack, pre-natal monitoring, etc. However, this has to be analyzed further. Firstly, and very importantly, micro studies do not always compare use with need, and inequalities in use therefore cannot always be interpreted as inequity or a violation of the principle of «equal treatment for equal need». Secondly, the apparent contradiction between macro and micro studies may not be a real one and may instead be a question of slightly inadequate data. In some studies using more complete data, this contradiction disappears. However, it may also be the case that the contradiction is revealing specific situations of discrimination involving particular groups or treatments which are concealed by the macro studies.

There are certain parallels between the literature on health inequalities and the study of variability in medical practice. The principal difference between the two areas of study, according to Ricard Meneu and Salvador Peiró[4], is that the former identifies the cause of the inequalities in the fact that the system offers different treatment to individuals who are essentially the same apart from differences in their socioeconomic condition (income, gender, ethnic background, etc.) which are not relevant to their need for medical care. By contrast, research into variations in medical practice studies inequalities which are the result of the different ways in which health professionals respond to situations of uncertainty. While such inequalities in care received can be objectively identified, they do not necessarily reflect inequity. Among other reasons, because they are often not compared with need. And nor is it clear that inequity, when it occurs, always favours those who receive more health services, given that «more» is not always «better» when it comes to medical practice. More visits to specialists by the richest and/or the most highly educated –as revealed by macro studies– is not necessarily better than frequent visits to one's family doctor. In fact, there is no clear consensus as to the most desirable pattern of visits to general and specialist physicians.

---

[3] Urbanos, R. and Meneu R. «La investigación sobre desigualdades en utilización de servicios sanitarios y sus distintos abordajes». In Rodríguez, M. and Urbanos, R. *Desigualdades sociales en salud. Factores determinantes y elementos para la acción*, Elsevier-Masson, Barcelona, 2008.

[4] Meneu, R. and Peiró, S. «*Disparidades en la efectividad y utilización de los servicios sanitarios e implicaciones de equidad*». In Rodríguez, M. and Urbanos, R. «Desigualdades sociales en salud. Factores determinantes y elementos para la acción», Elsevier-Masson, Barcelona, 2008.

- In their work, these authors analyze the relationship between effectiveness, utilization, variability and inequalities, and the implications for equity. Their conclusions are worth bearing in mind when we discuss inequalities and the role of the health system:
- Differences in morbidity do not satisfactorily explain variations in medical practice between similar areas. Resource differences explain more.
- Rates of utilization of treatments whose efficacy has been demonstrated are fairly similar, something which is good news.
- However, empirical evidence reveals significant variation with regard to elective processes or processes whose effectiveness is questionable.
- Finally, geographical inequalities are of greater magnitude than socio-economic ones, even though they have received less attention.

Prioritization in waiting lists as a possible source of inequality

In public health systems, the price paid by the user at the moment of consuming the service is usually zero or close to zero, depending on whether the system involves contributions and how high these are set. This absence of a monetary price acts as an incentive to «consume» additional visits or treatments until the expected benefit from these approaches zero. In these conditions, there is usually an imbalance between the available supply and the potential demand, and this is managed through waiting times; in other words, the patient pays a price in time instead of in money. This is particularly the case in «National Health Service» style public health systems which have more or less fixed global budgets. As a result, waiting lists are an integral part of this sort of system. Indeed, an interesting paradox occurs, which is that if waiting times are reduced the number of patients joining the queue may actually increase, because the reduction in the waiting time may further stimulate demand.

Tables 3 and 4 present the latest available data on the length of surgical waiting lists in Spain.

Table 3

Waiting lists for surgery in the Spanish National Health Service
Data to 30 June 2007. Distribution by specialism

SPECIALISMS	Total no. of patients on structural waiting list (*)	Difference compared to June 2006	Rate per 1000 inhabitants	Percentage waiting over 6 months	Average waiting time (days) (**)
General and digestive surgery	69,208	-1,887	1.77	5.68	67
Gynaecology	21,820	-545	0.56	3.13	60
Ophthalmology	76,479	-3,959	1.95	4.22	61
Ear, nose and throat	28,607	-264	0.73	4.17	64
Trauma	96,655	-4,671	2.47	9.98	82
Urology	25,527	87	0.65	5.00	64
Cardiac surgery	2,357	240	0.06	4.84	69
Angiology/vascular surgery	9,323	-1,092	0.24	5.37	71
Maxillofacial surgery	3,917	-1,382	0.10	7.56	85
Paediatric surgery	8,875	-355	0.23	5.01	74
Plastic surgery	10,173	-370	0.26	9.12	89
Thoracic surgery	933	29	0.02	10.18	76
Neurosurgery	5,610	-164	0.14	8.15	91
Dermatology	5,418	-470	0.14	0.15	39
TOTAL	**364,901**	**-14,803**	**9.33**	**6.25**	**70**

Source: Waiting Lists Information System of the Spanish National Health Service
(*) The data for one Health Service has been estimated using the processes selected / No data for one Region
(**) No data for two Health Services

Table 4

Breakdown of waiting time by specialism

☐ Number of patients waiting ▨ Average waiting time in days

	General and digestive surgery	Gynaecology	Ophthalmology	Ear, nose and throat	Trauma	Urology	Cardiac surgery	Angiology/vascular surgery	Paediatric surgery	Plastic surgery	Thoracic surgery	Neurosurgery	Dermatology	Maxillofacial surgery
Basque Country	3.310	993	3.969	1.081	4.133	858	50	577	442	336	35	170		132
	54,6	55,4	48,8	50,6	55,8	54,9	40,4	52,7	49,6	57,8	27,7	53,1	-	58,4
Cantabria	2.678	690	2.216	682	5.064	967	38	126	280	191	49	94	-	227
	112,6	**134,3**	**115,2**	**133,9**	**202,1**	**134,2**	56,2	**104,7**	**134,68**	**162,1**	45,8	49,2	-	**174,1**
La Rioja	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	37	37	45	44	51	41	15	21	-	38	6	-	17	-
Andalucia	10.583	2.511	9.625	4.090	12.819	2.859	579	568	947	609	107	631	877	243
	54	58	47	59	65	50	65	60	63	65	47	69	41	65
Galicia	6.037	1.722	6.606	1.839	8.855	2.679	534	1.491	1.152	1.080	92	585	363	401
	86	57	70	68	103	79	**108**	68	88	82	52	**95**	47	88
Extremadura	2.397	1.103	3.018	1.117	2.515	1.067	4	196	132	548	15	177	371	80
	55	67	73	61	67	63	13	43	43	141	23	69	49	34
Castilla and Leon	3.911	1.995	4.629	1.943	5.192	2.183	117	655	149	963	**55**	286	474	224
	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Castilla-La Mancha	2.991	842	2.695	1.421	3.831	1.654	0	203	458	308	7	185	1.232	-
	58,5	57,1	49,1	76,3	71,2	53,8	0	71,3	68,0	94,2	34,7	66,4	37,4	-
Melilla	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	25,8	27,4	32,3	22,9	18,5	36,8	-	-	-	-	-	47	50,8	-
Ceuta	81	12	86	33	91	25	-	-	-	-	-	-	-	-
	94	60	78	89	98	80	-	-	-	-	-	-	-	-
Murcia	3.036	628	3.284	1.169	3.816	972	19	191	412	367	19	144	226	190
	56,0	70,6	54,3	59,3	71,2	50,9	63,3	46,9	52,2	76,7	28,1	93,7	**53,6**	60,1

EXCEPTIONS IN EACH REGION

Madrid: Not included in list because waiting times not calculated using method which is consistent with other regions.

Catalonia: Not included in list because data only supplied for 14 most frequent operations.

Navarre: Not included in list because data only supplied for 11 most frequent operations.

Valencia: Not included in list because data only supplied for 10 most frequent operations.

Cantabria: Specialism «angiology/vascular surgery» does not include angiology.

La Rioja: Specialism «angiology/vascular surgery» does not include angiology. Number of patients not included because this was not supplied.

Canary Islands: Not included in list because data provided for each hospital and in percentages.

Castilla and Leon: Average waiting time for each specialism not provided by this region.

Melilla: Number of patients waiting does not appear because this region only supplied percentage of patients waiting.

Ceuta: Specialism «general and digestive surgery» only includes general medicine.

Asturias: Not included because no data supplied.

Aragon: Not included because no data supplied.

Baleares: Not included in list because data only supplied for 10 most frequent operations.

A few observations are called for here:

- Only 14 procedures or pathologies are monitored, some of which are so broadly defined that it is impossible to identify the real situation for specific procedures or treatments. Furthermore, these 14 procedures have remained unchanged for several years, despite the fact that changes or advances in medical and surgical practice in some specialisms have occurred.
- There is a lot of variability both with regard to the number of patients waiting and the average waiting time. Seventy days is not generally a very long time, but this average figure may conceal some far longer waiting periods.
- There is also a lot of variability between different regions, although any statement in this regard must be qualified by the lack of homogenous data (a glance at the long list of exceptions which accompanies Table 4 is enough to confirm this). This is one of the main problems identified by all experts in this area. The criteria used when drawing up waiting lists –not to mention the «tricks» to disguise them and simple administrative errors in gathering and preparing data– are not identical across Spain.

Various «solutions» to the problem of waiting lists have been proposed. One approach is to increase the resources allocated to health, in general, and to the procedures or pathologies with the longest waiting times, in particular. However, this increase in supply is obviously subject to budgetary restraints. It is not possibly to indefinitely increase health funding because this would take resources away from other uses (education, justice, pensions, public investment etc.) which also have legitimate claims for growth. Public funders thus have limited room for manoeuvre. Another option is to redistribute health funds, but this also affects the interests of the services to be cut. It is also possible to improve the productivity of doctors and hospitals, but while this is always desirable and may alleviate some of the problems of waiting lists, it cannot abolish them, because of the paradox we mentioned earlier. On the demand side, it is sometimes proposed that co-payments be introduced to discourage the mildest cases. But because demand for the service and inclusion on waiting lists depends, in the majority of cases, on doctors rather than patients, this measure would not appear to be advisable. (Leaving aside the issues of equity which such an approach would raise.)

In these circumstances, the best approach is to seek to manage waiting lists as effectively as possible. However, this is far more complex than simply applying a «first come, first served» rule. Instead, such management must pursue various goals at the same time. Firstly, there are goals of efficacy and efficiency. To achieve these, it is necessary to first evaluate cases as they join the waiting list, to confirm that the decision is correct and to reduce the inappropriate use of resources. This should reduce the number of patients on the list, and cut waiting times. The other type of measure involves designing appropriate ways of prioritizing the waiting list. There are many possible criteria for prioritization, but from the perspective of efficacy and efficiency, the options usually involve prioritizing the treatment of those who will derive most benefit from it (health improvement) or prioritizing the treatment of those who will suffer most from waiting (due to disability, restrictions on the patient's ability to work or to perform activities of daily living, pain, loss of salary, etc.).

Logically, different patient selection rules lead to differences in terms of the health benefits obtained, the number of patients treated, waiting times and the amount of suffering as a result of waiting. In addition, these prioritization criteria may be in direct conflict with another of the aims of waiting list management, that of equity (understood here to mean preventing socioeconomic variables from influencing waiting times).

No country explicitly includes criteria which take into account the patient's social position in the management and prioritization of waiting lists[5], but it remains the case that in many places it is the most disadvantaged members of society who end up waiting longest. The following table summarizes several studies which support the claim that socioeconomic status (sometimes) influences waiting time.

---

[5] However, it is not unusual for the issue of whether the patient is being cared for or cares for somebody else to be taken into account on an informal basis. These two criteria received a considerable level of support in interviews with members of the general public in the study by Sampietro-Colom, L. et al. which considered people's preferred criteria for prioritizing patients waiting for cataract surgery: «Prioritization de pacientes en lista de espera para cirugía de cataratas: diferencias en las preferencias entre ciudadanos», *Gaceta Sanitaria* 2006; 20(5):342-351.

- Pell et al., *BMJ, 2000*: Individuals with a lower socioeconomic status wait longer for cardiac surgery, primarily because they are less likely to be classified as urgent.
- Kelly et al., *Can. J Surg, 2002*: No differences in waiting times were found due to socioeconomic variables (age, gender, education and employment status) for hip and knee implants. However, neither do variables relating to the patient's health status explain the differences in waiting times.
- Fitzpatrick et al., *J Evaluation in Clinical Practice, 2003*: Significant differences in waiting times for hip implants on the basis of social class, geographical location and factors linked to the health system itself.
- Oniscu et al., *BMJ, 2003*: Women and poor people are less likely to be selected for kidney transplant. Once on the list, there are no differences in waiting time.
- Hacker and Stainstreet, *J Public Health, 2004*: There are no socioeconomic differences in waiting times for orthopaedic surgery, but for ophthalmology, women, the elderly and residents of poor areas wait longer than average.
- Regidor, et al., *Gaceta Sanitaria, 2006*: Individuals with a lower socioeconomic status (bottom income quartile) face longer waiting times for hospital admission.

Unfortunately, there is not sufficient information to enable us to know whether the longer waiting times for disadvantaged patients are due to discrimination by health professionals, even if this is unconscious, or because these patients are not as skilled at communicating the urgency of their situation or demanding treatment. In any case, there is no doubt that this phenomenon could broaden socioeconomic inequalities in health. And this is despite the fact that there are various studies which confirm that the public in general have a greater aversion to socioeconomic inequality in health than to inequalities per se[6]. That is, when members of the public are asked, they show

---

[6] Metzger Torelló, X. and Abásolo Alessón, I. «Aversión a la desigualdad socioeconómica en salud». In Rodríguez, M. and Urbanos, R. *Desigualdades sociales en salud. Factores determinantes y elementos para la acción*, Elsevier-Masson, Barcelona, 2008.

a strong preference for allocating more resources to protecting or improving the health *of the poorest* because they are poor, even if this entails a loss of overall (health) efficiency. However, when it is the rich who have a greater risk of becoming ill, the aversion to inequality is less.

What is clear is that health inequalities are influenced by both social and personal factors of which our knowledge is far from complete, and inequalities in the utilization of health services may also be affected by personal factors: a greater or lesser willingness to use the health system, the level of trust in treatments, etc. However, there is no such attenuation of inequalities in waiting times, once we accept that the decision to apply a particular treatment is correct. Indeed, we might even argue for positive discrimination in waiting lists, in the sense that health inequality should be a criterion to apply when prioritizing waiting lists with the aim of correcting the tendency to relegate some individuals due to their social status.

Ethics and prioritization in health waiting lists

Àngel Puyol
Lecturer in Ethics at the Autonomous University of Barcelona

The health service increasingly finds itself confronting issues relating to the fair distribution of available resources. We should remember that justice is one of the fundamental principles of bioethics, together with beneficence, non-maleficence and independence, even if it is the principle which receives least attention both in academic discussions and in social and political debates, with the exception of the occasional appearance in the media as a result of specific cases which cause great public indignation for a few days, but which fade away as soon as the problem is patched over with some short-term (or opportunistic) institutional measure. Meanwhile, the underlying issue of how to choose between services and patients in the context of limited resources remains unresolved.

Naturally, this choice has a financial basis. While we would hope that efficiency plays a role in all such decisions, we should be aware that efficiency is not a magic wand which banishes moral conflicts, and nor is it value-free. For example, when we decide to prioritize a cheap, effective medical treatment for the majority of patients, in preference to a more expensive, less effective one which only offers benefits to a minority, we are clearly acting efficiently. But if we consider that the rejected treatment may be the only one which is effective for the minority, then we have to accept the unavoidable ethical consequence of our efficiency: we are choosing the well-being of some patients (the majority) over the well-being of others (the minority). This choice has bad consequences for those individuals whose only crime is that they belong to a minority of patients for whom the most effective treatment is too expensive. Neither of this facts is the fault of the patients themselves. In this case, therefore, efficiency penalizes them without their having done anything to deserve this, and without their being able to do anything to change the situation. Is this fair? Maybe, or maybe not. But there is no doubt that we must consider the justice or injustice of this social choice, and that this cannot be reduced to the supposed ethical neutrality of efficiency to which some aspire.

The social and health environment in which we live is a paradoxical one, where we have seen spectacular medical advances over recent decades, but at great cost, with the result that it is impossible to guarantee that all patients will receive the health care they need. In light of this, there is no choice but to introduce criteria of justice in the distribution of limited health resources.

Unfortunately these criteria are not usually publicized or explained properly. Indeed, just the opposite occurs, and the prioritization or rationing of health resources often occurs in an arbitrary, secretive manner. Waiting lists are one of the clearest and most visible examples of health prioritization. In this paper I will seek to briefly assess the different ethical criteria for evaluation found in health waiting lists and will consider the issue of whether the criteria used should be made public.

The first thing to be said is that health waiting lists are inevitable, given that these are a consequence of the need to regulate the relationship between supply and demand. Imagine that ten patients show up to see the doctor at the start of the day. The doctor has all morning to attend to them, but they obviously cannot all go in at once. A waiting list has thus been created. This raises two ethical questions: 1) Should we hire more doctors to abolish or reduce the list?; and 2) If it is not possible to abolish or reduce the list, then what system should be used to decide who should have priority? With regard to the first question, it would not seem to be reasonable to hire as many doctors as there are patients, unless the patients require attention urgently. For the majority of health treatments, the desire to avoid a few hours wait does not justify multiplying our resources by a factor of ten. If the majority of patients can await their turn without their health deteriorating significantly, it would clearly be both inefficient and wasteful to provide one doctor for every patient. But let us now suppose that the waiting list is not a few hours but six months, or that all the cases are urgent, with the result that waiting would lead to a serious deterioration of the patients' health. In these cases, the waiting list is of much greater ethical significance and, if a society has economic resources which it does not invest in abolishing the waiting list, it must accept the ethical consequences.

However, I do not wish to talk about whether health rationing is more or less avoidable. Instead, I would like to focus on the second question, which is also of ethical significance. Let us imagine that we are faced with a waiting list.

What criterion or criteria should we use to prioritize patients on the list? There are a number of candidates: the order of arrival, the seriousness of the patient's condition, private capacity to pay (to meet the cost either in part or in full), the social utility of the patient, the capacity of the patient to benefit from medical services, individual responsibility for acquiring the disease, the likelihood of compliance with the treatments prescribed, age, etc. The ethical implications of prioritization are far greater if, as mentioned earlier, instead of a few hours' wait we are talking about weeks and months, or in the case of inherently limited resources such as organs for transplant.

It should be clear, in any event, that the two questions generate different ethical problems. It is one thing to determine the quantity of health resources which a society should provide, and quite another to identify, in the light of available resources, how these are or should be fairly distributed. For reasons of space, I will confine myself to the second question.

Before I do this, I would like to clear up a common misunderstanding. There are some who believe that health prioritization criteria obey, or should obey, clinical requirements and not requirements of an ethical or some other nature (social, economic, political, etc.). However, while clinical knowledge may tell us what to do in order to cure a patient or mitigate his suffering, it cannot tell us who has priority to receive treatment. One might think that the most seriously ill should have priority, but this is an ethical question, not a clinical one. In fact, doctors do not always believe that those patients who are most ill should be given priority. For example, would we allocate all the available resources to an elderly patient with a terminal illness in order to extend his life for a few weeks if this meant refusing medical treatment to large numbers of young people with serious but treatable illnesses? If we respond to this situation by arguing that there are clinical reasons for not prioritizing the elderly patient, then we have to redefine what is meant by clinical criterion, because there is no doubt that, in this case, he is the most seriously ill patient. Continuing in this vein, we will soon find that prioritization criteria which appear to be clinical quickly become confused with social and above all moral criteria. The response to the question, «who most *deserves* the available health resources?» cannot be answered from a purely clinical perspective. It is, ultimately, a question of ethics or justice.

At the same time, it should also be noted that on occasions the clinical argument is used in a demagogic fashion to conceal the problem of limited resources. It is not uncommon for the health system to pressurize health professionals into internalizing resource limitations and adapting their clinical practice to this situation. For example, if there are a lot of patients waiting to see the doctor during the course of the day, then the less seriously ill are allocated less time, with the resultant message that it is not so necessary, *from a clinical point of view*, to dedicate more time to them. But this is not necessarily true. What happens is that the pressure to attend to so many patients dresses up in clinical garb a priority which, in reality, is ethical and is conditioned by resource limitations. One might argue that this priority is based on an economic interest: to save human resources (doctors etc.) in order to make patient care cheaper. But let us not deceive ourselves. Behind this possible economic interest is a moral choice to dedicate more resources to other spheres or areas of society. In the case of public health, this moral choice may favour public investment in education, defence or infrastructure, or it may favour private consumption by reducing taxes. Whether these strike us as good moral alternatives or not, it is clear that the clinical or economic cloak which typically conceals these priorities should not hide the fact that it is, at bottom, a moral choice.

Even the decision to send a patient to hospital, when this is not an emergency, usually depends on the resources available. Take the case of a patient who needs a test to refine a diagnosis and minimize the risk of error. If the hospital has the equipment needed to perform the test, the patient is referred. But if the hospital does not have the equipment or is overloaded so that it is not possible to perform the test before treatment would have to commence, then it is best not to prescribe the test. Why? Often, the pressure of the system makes doctors think that the patient «doesn't need» the test. However, the reality is that it «is not available for him» and there is a more advisable course of action in this case. But it is not true that he does not have a clinical need for it. If it was really available (if, for example, there was not such a long waiting list) he would need it, clinically speaking. Sometimes patients are told that the best treatment for them is treatment B when, in reality, in ideal clinical terms, it would be A. What happens is that A is much more expensive and does not form part of the patient's health coverage or there is such a long list that it is advisable (on clinical grounds) to commence with treatment B. Normally, the patient is not told the real reason for treatment B being proposed, which is simply that the available resources are insufficient. Instead, the patient may receive a message from the health system that the treatment that he «needs» is B. This is obviously true, but only because there is a context of limited health resources, not because this is the treatment he would need on purely clinical grounds. With more money or available resources (and this is what is concealed) clinical grounds would advocate treatment A.

In other words, given that the indicated treatment is more or less effective depending on the available resources, indicating one treatment or another may appear to be based solely on clinical or medical criteria, but in reality this decision also involves related aspects such as the availability and restriction of resources. Confusing «the best clinical option» with «the best clinical option given the available resources» is similar to treating as scientific an argument which is not.

The prioritization of health care is not a purely clinical problem, but rather a political one, and it always has an ethical basis: which moral values provide the basis for prioritizing some patients in preference to others. These values may be related to the compassion we feel when witnessing patients' suffering and the seriousness of their condition; they may concern the desire to favour those who will derive most health benefit from medical services; they may derive from the moral conviction that we should help those who are worst off (whether we define this in terms of pain, prognosis, lack of opportunities, difficulty in serving the community, etc.); they may come from the moral desire to make people take responsibility for their actions or the wish to give everyone what they «deserve» (however this is defined); or they may reflect the wish to even out opportunities of living a healthy life. The problem is that these values are hardly ever compatible with each other, with the result that we are forced to choose between them.

Below, I will briefly summarize the pros and cons of the ethical criteria most frequently used as the basis for making prioritization decisions regarding waiting lists. My aim is to raise awareness of the moral conflicts which underpin health prioritization decisions, and to show that these conflicts cannot be resolved with on the basis of strictly clinical arguments, that is, without recourse to ethics and politics. We must choose ethically, and we are all responsible for the choices which affect society as a whole, including those taken by an individual health professional with regard to an individual patient, using resources which belong to all of us.

The most frequently used criterion for prioritizing within a public health waiting list is probably the *order of arrival*, or «first come, first served». The advantages are obvious. It is impartial, because priority appears to rely on chance, leading people to believe that it does not involve favouritism. Nobody can say they have been treated unfairly, and this is very important from the perspective of justice. What is more, it does not pose problems of how to calculate it: it is easy to check the order of arrival. Finally, it is a traditional criterion and is therefore widely accepted by the public.

However, it is not without its problems. On occasions, the first person to arrive, or the one who has been on the waiting list for longest, is not the most seriously ill or the one with the greatest capacity to benefit from health resources. In addition, it may discriminate against patients who for cultural, educational or other reasons are not as skilled, as fast or as effective as others when it comes to accessing waiting lists. As a result, the order of arrival needs to be modified by other criteria which may, at times, complement or replace chance in deciding access to medical care. We should also realise that while chance is, in itself, an impartial criterion, the decision to choose the order of arrival as a criterion for prioritizing care is not. Placing the order of arrival before other criteria is not a random choice and must therefore be justified on ethical grounds.

Together with the order of arrival, the *seriousness* of the illness is frequently used as a criterion for prioritizing waiting lists. The idea that the most seriously ill should be given priority over the rest is one which is deeply rooted in all of us and can be observed spontaneously in any medical surgery. In the waiting room of any hospital or primary care centre, nobody would dream of insisting that the order of arrival should be enforced strictly when a person with very serious symptoms arrives. And when surveys are conducted to identify the fairest criteria for accessing limited health resources, seriousness is the most highly valued criterion among the general public and health professionals alike.

However, sometimes there are good reasons for not giving priority to the most seriously ill. To start with, we cannot always be sure who the most seriously ill person is. Medicine is not an exact science, and prognoses are often debatable. When we are not sure who is the most seriously ill, the criterion of seriousness is of no use in allocating priority within the waiting list.

In second place, it is questionable whether those who are most seriously ill are really worst off. Perhaps we should prioritize those who have the poorest well-being in general, something which goes further than just the individual's state of health. One might argue, for example, that a poor patient, who is unemployed, with a large family to maintain and with a past life of undeserved suffering, deserves higher priority than another patient whose life is normally far less turbulent, has no family responsibilities and has enough resources of his own to overcome the material adversities of life, even though he is actually slightly more ill than the first patient. We could also argue that those who are worst off are not the ones whose condition is most serious, but rather those patients whose overall health is worst. For example, let us suppose that John's hip condition is worse than Edward's, but that Edward's overall health is much worse than John's. Who should have priority on a waiting list to receive the hip replacement which both of them need?

Thirdly, the criterion of seriousness is prey to a moral contradiction, what is known as the Rule of Rescue. According to this rule, it makes little sense to invest all of one's scarce resources in somebody who is dying while doing nothing to improve the situation of large numbers of patients who could benefit from the same resources. We do not have to abandon the dying person, but allocating all the available resources to him when the treatment is likely to have little effect would not appear to constitute the best ethical solution if the same resources could yield far greater health benefits in large numbers of patients. For example, nobody would consider giving a heart transplant to a patient who also has advanced, untreatable cancer of the pancreas if the same heart could extend the life of another patient for many years, even though it is clear that the health situation of the first patient is far more serious and the new heart would deliver a great health benefit, even if only for a short time.

To overcome this problem, some have argued that health need should not be measured in terms of the seriousness of the patient's condition, but rather the patient's *capacity to benefit* from medical treatment. After all, if the duty of the health system is to increase people's health, maybe the priority should be to maximize the population's health and, to achieve this, we have to prioritize those patients who would obtain the greatest health benefit from the health services. This argument has a utilitarian moral basis, and is usually implemented using the formula of QALY (quality adjusted life years), according to which priority is given to those patients with the greatest prospects of health improvement (measured in terms of years and quality of life gained). Not only does this avoid the problem of the Rule of Rescue, but it is also an efficient criterion both in purely health terms (because it succeeds in extracting the greatest overall 'quantity' of health from each unit of health resources) and in economic terms (because if we relate it to the cost of the health resources, it always seeks out the best cost-effectiveness ratio).

However, the criterion of QALY or cost-effectiveness raises serious ethical problems. Firstly, it would appear to discriminate against the most seriously ill who, in many cases, score lowest in terms of cost-effectiveness for the majority of medical treatments. In addition, it gives out a message which would seem to be surprising and paradoxical for a public health system: «the more ill you are and the more need you have of expensive public services which you cannot pay for privately, the lower down the waiting list you will be due to the likelihood that your treatment will be less cost-effective than that of other patients.» However, the greatest ethical problem relates to a moral fallacy. According to the utilitarian criterion, we should accept that the health losses of some individuals are compensated by the health gains of others. By doing this, we are reducing these individuals to mere recipients of utility or health. In philosophical terms, we are thus ignoring the *moral separation* of individuals, the conviction that they are separate moral entities. For example, if Mary has a miserable life or suffers from a painful disease, her situation is not remedied or compensated by ensuring that Sarah is happier or more healthy.

It is true that, on occasion, we may believe that such compensations are morally legitimate, given the alternatives. For example, in war it is argued that some deaths may contribute to improving the situation of those who survive. But in this case we must also accept that individual rights are less important than collective achievements. Once again, there is a moral conflict. What we have to decide, in our case, is whether access to health should be ruled by the moral logic of a wartime situation (in which field doctors prioritize those who have the greatest possibility of returning to the front … for «the good of everyone») or by other, less desperate, forms of moral logic. A third option is to search for a combination which reflects the context of limited health resources of today's society.

A variation of the utilitarian model, but with a different concept of equity, is that referred to as *fair innings* or prioritizing individuals who suffer from greater health inequalities. According to this criterion, waiting lists and health priority systems in general should take into account the number of years and quality of life that a person has, *has had* and is predicted to have as a result of the health intervention. The moral intuition on which this is based argues that everyone has the right to live the same number of years and with a similar quality of life. Anything beyond that is not a right but rather a piece of fortune for the person who receives it, without this prejudicing anyone else, or an undeserved privilege for someone who obtains it to the detriment of others. The age of the patient therefore becomes a fundamental criterion when deciding how to allocate limited health resources, and this includes waiting lists. This moral intuition has a solid cultural basis, reflected in the notion that «it is a disaster to die young, but it is not a tragedy to die old». It also has a clear, progressive basis, given that those from lower social classes suffer from health inequalities on a more or less systematic basis. And it is also efficient, because it frees resources from those patients who will derive least benefit from them, to those who will benefit most, within the limitation placed upon this efficiency by the moral restriction of reducing health inequality on the terms described.

But it also poses some ethical problems. For example, it discriminates against the old for the mere fact of being so. Of course, we could argue that this is a lesser evil, for the cultural reasons already mentioned, and indeed surveys which ask people to prioritize limited health resources usually agree that age is a morally acceptable criterion for exclusion. No morally mature culture sacrifices its children for the greater well-being of its elders, but it may permit the opposite. However, we may ask ourselves whether a morally more acceptable alternative exists. For example, why should the old pay for the good health of the young and not others, such as the rich? If the wealthiest paid, this would reduce the need for the elderly to do so and it would also increase the overall health of the population and reduce health inequalities. After all, the rich would also receive the health care they need (in the private health care sector) and there would be more resources overall to deal with a greater number of health needs, something which would in turn reduce the resource restrictions. However, this solution faces a clear political difficulty: the resistance of the wealthiest to paying more for a service of which they will receive less. But this is more a political than a moral objection. What moral argument could the rich offer for refusing to improve the health of all and reduce health inequalities? In the United States, for example, many people believe that the moral rights associated with obtaining wealth are more important than the right to health. But that is another debate, and at the start I said that I would focus on the ethical criteria for prioritization, «given limited health resources».

Before concluding, I would like to consider a few more criteria which, although they are less transparent, are no less frequently used.

One of these is *nepotism*, which consists of giving priority on waiting lists to the relatives, friends and acquaintances of health professionals. Because it is not a publicly stated criterion but rather one which is used surreptitiously, rather than talking of prioritization one might say that applying this concealed criterion when using resources involves *jumping the queue*. But should it be an open, public, recognized prioritization criterion? After all, helping your loved ones is a moral duty which we all accept, and nepotism is a practice which is tolerated and accepted by many medical professionals, even if hardly anyone defends it in public. Even the professionals who do not practise it themselves do not denounce it. Some professions have regulated nepotism to make it legal, as is the case of railway employees or university staff, who receive special discounts and reserved places for direct relatives. What, then, is so wrong about using nepotism on health waiting lists? If it is so common, why can it not be public? Why can a doctor not be open about the fact that he has pushed his father or son to the front of the official list? Would society not understand and approve of such a very human piece of behaviour?

There are various reasons for preventing the use of nepotism for public health waiting lists. Firstly, because public resources belong to everyone, and it is therefore unjust when a few people have privileged access to them. There can be no justice without impartiality, and nepotism is partiality writ large. But it is also true that there can be no morality without moral commitment, and commitment or loyalty to those to whom one is close is an unquestionable moral requirement in our moral life. Secondly, and more importantly, unregulated nepotism is a bottomless pit. Who is one closest to? How many moral obligations do we have to *our own*? It may be possible to publicly justify favouring a father or a son, but doing the same for your brother-in-law's friend or a relative's boss is another matter: nobody would tolerate it. Perhaps, for this reason, nepotism is not regulated, because there is no professional interest which limits its use, and there is also no social interest in legitimating a practice which is immoral in principle. As a result, unregulated nepotism harms both the general public, who lose out through the waiting list system, and health professionals themselves, whose image is damaged. Regulation with fair restrictions would undoubtedly be a suitable solution.

Another factor which sometimes affects waiting list prioritization, either consciously or unconsciously, is how *pleasant or disagreeable* health professionals find their patients. Patients who make a good impression on those who are responsible for the lists or those who have influence over them are more likely to benefit. And, paradoxically, the most disagreeable patients may also enjoy the same benefits; an annoying, persistent, complaining or difficult patient may have the same effect as the nicest one, as doctors do what they can to «get him off their backs». Of course, prioritization for either reason is clearly unfair because it discriminates against all the other patients.

Another health prioritization criterion consists of handing responsibility to the general public, and on occasion *public opinion* has been used to clarify prioritization criteria for accessing limited health resources. The state of Oregon, in the 1980s is a well-known example of this. In this approach, people are asked what prioritization criterion should be used. If we agree that the criteria are not purely technical or clinical but have, instead, a significant moral or political component, why not leave the choice to democratic society? In the face of irresolvable moral conflicts which affect all of us, it is not a bad solution to leave the final say to citizens and, in passing, to relieve health professionals of their responsibilities.

But it is not so simple. The experience of Oregon shows some of the weaknesses of this approach. For example, in consultations and surveys to determine health priorities in the state of Oregon, one feature was the low priority given to treatment for illnesses which were the result of habits considered to be socially undesirable, such as alcohol abuse and drug addiction. Another surprising outcome was a preference for funding patients who needed a wheelchair in favour of those in coma, probably due to the fact that it is easier to perceive the inconvenience of not being able to walk than the seriousness of being in a coma. Another surprising result was that the majority of those surveyed preferred funding spectacles to curing burns on parts of the body which are not visible.

In addition, it is not easy to prevail upon the general public to take responsibility for the need to prioritize limited resources. Most people see this as a problem to be resolved by doctors and politicians. And when ordinary people are asked to take responsibility for choosing criteria, we have seen that the subjective perception of illnesses which they have not experienced tends to distort the reality of which both health experts and those suffering from specific illnesses are well aware.

Another of the criteria to be taken into account when drawing up waiting lists is the *social value of the patient*. For example, under the same conditions, a patient with dependent family members or responsible for a large family might deserve priority treatment. The argument here is that the good we do to the patient is multiplied by the necessary social good which the patient exercises in his or her daily life.

However, this criterion also has its drawbacks. In the first place, we have to determine how to assess patients' social value, and this may also open the door to social prejudices. The temptation to believe that workers should take priority over those who do not work, that entrepreneurs should have priority over workers, that locals should be preferred to immigrants, the young to the old, in sum, the socially useful to those who are not useful, is always present in this criterion, and we have to be very attentive to this. Secondly, it is difficult to find the right way to combine this criterion with the others. For example, should we give priority to a patient's social value to the detriment of the seriousness of their condition, or should we only use this criterion to decide between patients whose condition is equally serious? Despite these problems, we should not ignore the criterion of the patient's social value.

Finally, we must raise the issue of the criterion of the *personal responsibility* of the patient. Since debate around smokers began in countries like Great Britain several years ago, the idea of penalizing patients whose illnesses are caused or clearly conditioned by behaviour of their own choosing has gained increasing currency. On the one hand, it seems reasonable that people be held responsible for healthy and unhealthy behaviours. On the other hand, it is not always easy to determine the scope and limits of individual responsibility. For example, many people start smoking during adolescence in order to gain social acceptance, and later some find it more difficult than others to give up, due to biological factors linked to addiction. As a result, while it is reasonable to demand that patients take responsibility for their lifestyles by including this criterion in any health prioritization system, it does not seem reasonable to give undue weight to individual responsibility to the detriment of social responsibility. In our society, health is more than just a personal privilege; it is also a right.

I have summarized the most significant health priority criteria without mentioning one which, in the context of public health, seems the most inappropriate of all: the *ability to pay*. Individuals' ability to pay is definitely a prioritization criterion. However, it is the most unfair of all if we start from the idea set out in the preceding paragraph, that health is a right and not just a privilege. But we should not forget that societies such as the United States remain convinced that the value of health has little to do with individual rights.

However, a strong commitment to public health does not mean that the ability to pay should not play any role in prioritization: in other words, that all the available health resources should be provided completely free of charge for everyone. If it can be shown that an additional financial contribution by patients not only does not harm equity but actually helps improve the access of all to limited resources, then it should not be ruled out as a fair prioritization criterion.

I have left for last a really difficult issue. Whichever the criterion used, or the combination of criteria chosen, for the prioritization of waiting lists, the question of whether to make this process public arises. In other words, should the ethical criteria for prioritization be made *explicit*, so that patients and the public as a whole know how waiting lists are really compiled, or is it better that the prioritization criteria used be kept hidden or *implicit*? There are arguments for and against both viewpoints. Let us start with the justifications for keeping prioritization criteria *implicit*.

First of all, we already know that there are different ethical criteria for prioritization and we cannot always state that some of them –or a particular combination– are clearly better than others. There is no single criterion which is universally valid for all cases. We have even seen that seriousness and order of arrival may not be morally acceptable criteria in some cases. If there is no single criterion which is clearly superior in all cases, and the public are aware of this, then controversy may make it even more difficult to reach the consensuses necessary to apply ethical criteria governing access to waiting lists. According to this approach, medical and political leaders should be responsible for taking decisions, without consulting or informing patients and the general public, in order to prevent a proliferation of debate, disagreement, controversy and confusion which could only make matters more difficult.

Linked to this argument is another which maintains that explicit prioritization or rationing would produce a huge *disutility*, due to the fact that patients and the general public would know they were not receiving certain treatments or not receiving them quickly enough for economic reasons linked to resource limitations or, in any case, for non-medical reasons (too expensive, too old, too responsible, too ineffective, too little social value, etc.). This knowledge of the truth would produce anxiety, indignation and frustration, both among health professionals, who would be changed from good Samaritans to rationing officers, and among patients, who would realize that they were being denied the resources they need for reasons other than medical necessity. There is also something inhumane in telling a patient, explicitly, that his illness could be treated but that the health system will not pay for the treatment or will not provide more doctors and services because this would be very expensive. It would therefore be better if patients believed that if they are near the bottom of the waiting list this is basically for clinical reasons, even if this is not the whole truth.

Thirdly, it can be argued that explicit prioritization has numerous administrative and political costs. It complicates the professional life of both doctors and nurses (who would be forced to consider moral questions which have little to do with clinical practice), that of health managers (who would have to establish public ethical limits in return for constant criticism from society in general and in particular from those patients who would fare worse as a result), and of politicians (who would be required to provide endless explanations of why people were being refused care for economic reasons, rather than for clinical ones). Furthermore, the differences between individual cases are so great that it would be impossible for the public to understand that what is morally good for one person is not good for another. Distrust towards the health system could become more widespread, in which case explicit prioritization, and the higher administrative costs associated with it, would have the effect of undermining the legitimacy of the health system. It would therefore be better if patients believed that the reasons for not being treated rapidly were always clinical or at least were not in conflict with such clinical reasons, even when this was false.

However, there are also arguments for prioritization being explicit, open, transparent and ethical. In the first place, although there are numerous criteria for accessing waiting lists, it would appear that those which are linked to the seriousness of the patient's condition or which are defined in terms of *need* should have a degree of priority. Need may be determined by the seriousness of the illness, by the patient's capacity to benefit from the treatment available or in terms of social needs relating to care for dependent relatives, but in any case need has moral superiority over social merit, age, personal responsibility, nepotism, pleasantness or the ability to pay. It is of course true that there is not always clear agreement about the appropriate combination of need-related criteria, and that we should not simply rule out those criteria which are not related to need, because some of them have a role to play in the prioritization process, but we must also recognize that need-related criteria provide the health prioritization process with moral legitimacy.

In response to the criticism that making health prioritization criteria explicit would give rise to social *disutility*, it might be argued that lies are scarcely a good way of generating social utility. The more mature a society is, the less willing it is to accept lies, even when these are told for paternalistic or benevolent reasons. In addition, the right to be informed is morally superior to the wish to avoid the frustration or disappointment which comes from hearing uncomfortable truths.

Making explicit the ethical criteria which underlie health prioritization decisions will generate administrative, political and professional costs. However, the rights of patients and society as whole to know the truth take priority over potential inconveniences for the system and the professionals who operate it. In addition, secretiveness in such a sensitive area could help produce abuses arising from arbitrariness and a lack of transparency.

In conclusion, I believe that the arguments in favour of making the ethical criteria for health prioritization, including waiting lists, explicit are stronger than the arguments against. Whether society is sufficiently mature to understand and support this is another question, but in principle backing social immaturity is never a good democratic policy.

Bibliography

Boixareu, R. et al., *La gestió de la salut, un repte ètic*, Prohom edicions, Barcelona, 2005.

Camps, V., López-Casasnovas, G, and Puyol, A., *Les prestacions privades en les organitzacions sanitàries públiques*, Informes de la Fundació Víctor Grífols, n. 4, 2006.

Defensor del Pueblo, *Informes, estudios y documentos: Listas de espera en el Sistema Nacional de Salud*, Madrid, 2003.

New, Bill (ed.), *Rationing. Talk and Action in Health Care*, King's Fund, London, 1997.

Puyol, Angel, *Justícia i salut. Ètica per al racionament del recursos sanitaris limitats*, Servei de Publicacions de la UAB, Bellaterra, 1999.

Raising awareness of waiting lists

Juan del Llano

Director of the Fundación Gaspar Casal

There is no doubt that the problem of waiting lists is one of the most serious challenges faced by any health system, regardless of how it is organized, managed or funded. Waiting lists are essentially a form of implicit rationing which arise when there is an imbalance between supply and demand in systems where the health services are provided by a public system offering free, universal healthcare. As Enrique Costas Lombardía explained in a recent article in *El País*[1], analyzing the issue in the Spanish regions, waiting lists are the product of a widely recognized economic mechanism. The goods and services which are produced are, by their nature, scarce, and there are only two ways of distributing or allocating them among the large numbers of people who want them: market pricing, which presupposes an ability to pay, and a «queue» which regulates consumption by order of arrival. In universally accessible, free public health systems funded from taxes which have suppressed market pricing with the aim of ensuring that all citizens receive equal treatment for equal needs, and provide care free at the point of consumption, access must be mediated by a «queue» system. The wait is, in other words, the inevitable concomitant of the fact that care is provided free of charge. It is not a failure but rather an integral component of free, universal healthcare. Despite the fact that they do not affect urgent cases, when serious delays occur, waiting lists are one of the major sources of dissatisfaction among health service users.

In Spain, in the wake of the Public Ombudsman's report in 2003[2], the management of waiting lists became a priority both for the Department of Health and for the Health Departments of Spain's Regional Governments, which have responsibility for health services. In the report, the Ombudsman identified the existence of waiting lists as the expression of a daily mismatch between supply and demand, and noted that while the lists included patients whose wait could be justified on clinical grounds, nobody could defend waiting times which were excessive and thus clinically and socially unacceptable. He criticized the existence of waiting lists of months or even years, with the result that during those periods citizens were effectively deprived of the right to health protection, and was also scathing of the inadequate management of waiting lists, the minimal transparency of information, and the insufficient development and clear failings of information systems, which undermined their validity and reliability. The report also highlighted the absence of centralized records in all cases and the failure to establish maximum waiting times, and criticized the existence of closed lists, preventing some patients from being informed of their treatment date, an issue which affected some hospitals in the regions of Andalucia, Aragon, the Balearic Islands, Castilla-La Mancha, Castilla-León, Extremadura and Madrid.

With regard to delays in appointments with specialists, there were delays of between six months and one year in all regions except for Asturias, Navarre, the Basque Country and La Rioja, with no information being available for Catalonia. In diagnostic tests and procedures, delays of this sort occurred in the regions of Andalucia, Aragon, the Balearic Islands, Castilla-La Mancha, Castilla-León, Valencia, Extremadura, Galicia, Madrid and Murcia. In the Canary Islands and Catalonia there was no information in this regard. Based on the information provided, patient waiting times for scheduled surgery were over six months in hospitals in every region with the exception of the Basque Country, La Rioja, Ceuta and Melilla. The regions with the longest delays for surgery, of several years in some cases, were the Canary Islands, Catalonia and Valencia.

The publication of this report coincided with the transfer of responsibility for health care from central government to the few remaining Spanish regions which did not already have these powers, and had a major impact on managers with responsibility for waiting lists, as it flagged up very serious errors in the organization of this issue.

Examples of measures implemented to address this problem include the Guarantee Act of Castilla-La Mancha and the Madrid Region's integrated plan to reduce surgical waiting lists.

---

[1] Enrique Costas Lombardía. «Los políticos no esperan». *El País*. 05/05/08.

[2] Defensor del Pueblo. *Listas de espera en el Sistema Nacional de Salud*. Informes y estudios 20.242 04/04/03.

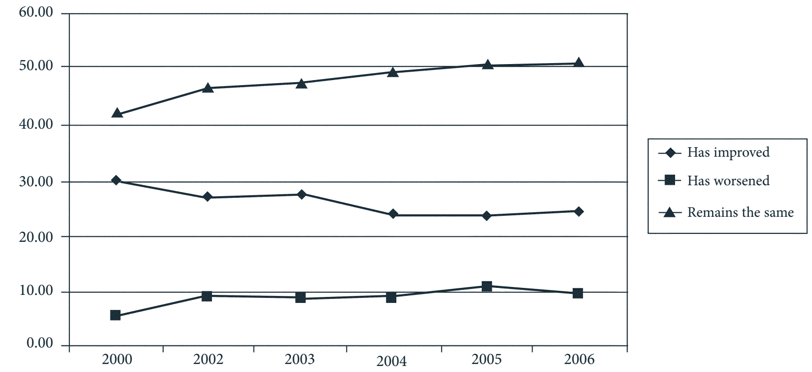
Public awareness of the existence of the problem

One key aspect is the awareness among the general public of the existence of the problem of waiting lists. In the annual health survey conducted by the Sociological Research Centre for the Department of Health and the Consumer during the period from 1996 to 2003, the perception of waiting lists for a range of different health services rose gradually, and by 2003 was higher than 81% for all categories (with the exception of waiting lists for hospital admissions, which already stood at 89.7% in 1996). The greatest increase relates to waiting lists for diagnostic tests, with perceptions rising from 73.3% in 1996-97 to 82% in 2003. These specific questions are no longer asked, and we are therefore unable to compare these figures with the current situation.

Current assessment of the problem by the general public

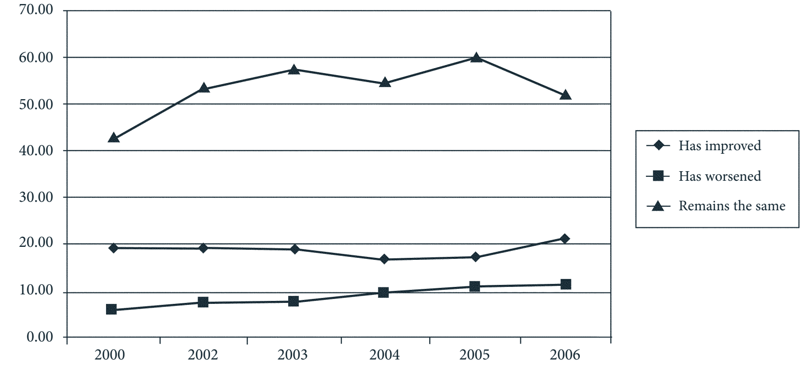
In 2006, 60.96% of the Spanish population believed that the problem of waiting lists remained the same or had worsened[3]. This percentage has remained constant over the years, while the proportion of respondents who believed that *waiting lists have improved during the last year* fell significantly in 2004 and 2005, before recovering slightly in 2006 (24.38%), while the belief that it had worsened grew significantly. In Catalonia, the percentage of people who believed that the problem of waiting lists had improved was even smaller, although it rose somewhat over the preceding two years.

NATIONAL. In general, do you believe that over the last twelve months the problem of waiting lists …?



Source: Health Survey 2000-2006

CATALONIA. In general, do you believe that over the last twelve months the problem of waiting lists …?



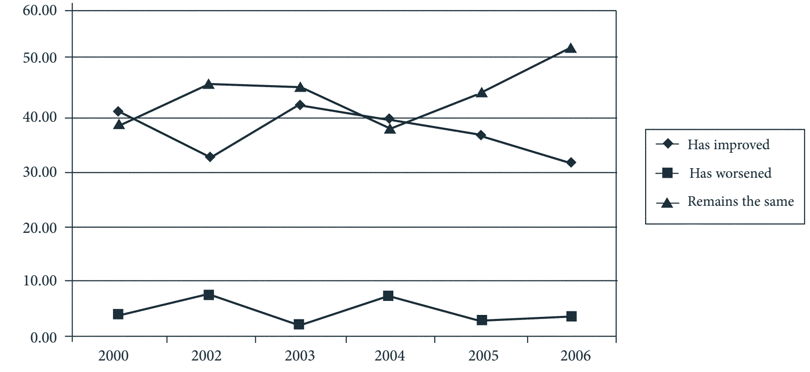
Source: Health Survey 2000-2006

With respect to the two proposals noted above, public opinion in Castilla-La Mancha has worsened since the introduction of the Guarantee Act, although it should also be noted that this is the region with the highest valuations in this area, with only Castilla-León rating higher in 2006.

---

[3] Barómetro Sanitario 2006. MSC.

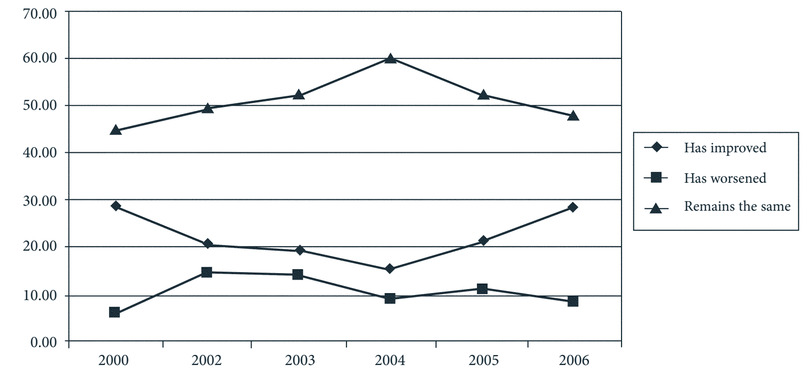
CASTILLA-LA MANCHA. In general, do you believe that over the last twelve months the problem of waiting lists …?



Source: Health Survey 2000-2006

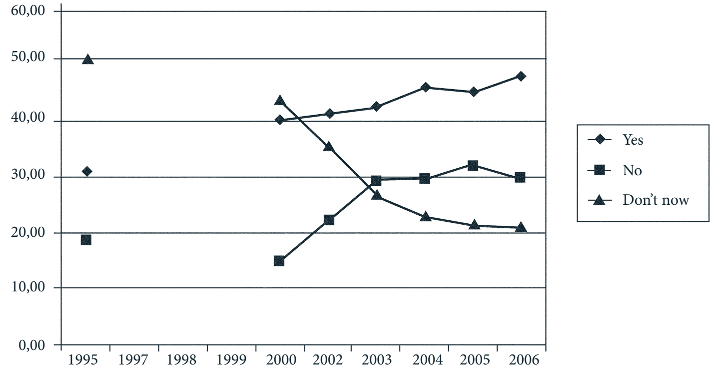
However, in Madrid the situation improved significantly from 2004 to 2006, although this only brought it back to the same level as for the year 2000.

MADRID. In general, do you believe that over the last twelve months the problem of waiting lists …?



Source: Health Survey 2000-2006

Do you believe that the health authorities are taking actions designed to improve waiting lists?



Source: Health Survey 2000-2006

With respect to the question as to whether members of the public believe that health authorities are taking actions to address the problem, awareness has continued to rise gradually, while the percentage of respondents who believe this not to be the case stabilized after rising sharply from 2000 to 2004. For the purposes of this discussion, it is also important to note that the percentage of citizens who do not know or have no opinion has fallen constantly since this question began to be asked.

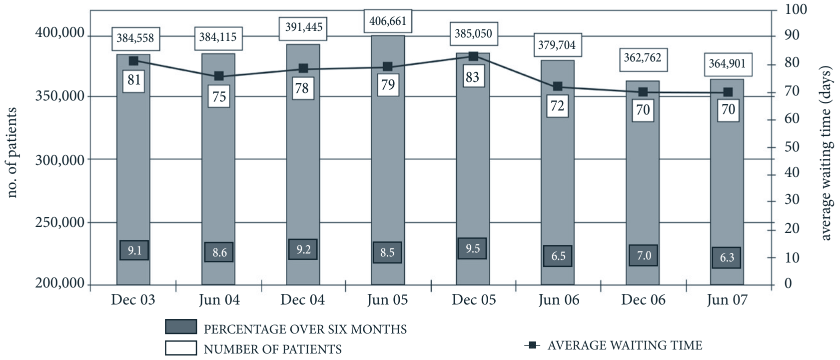
Looking at these two charts, we might conclude that people are aware that the authorities are working to improve the problem of waiting lists, but remain unconvinced as to the impact of these efforts.

Another finding to take note of is that 3.6% of the population were unable to receive health care during the previous twelve months, according to the 2006 National Health Survey. This data is difficult to interpret, but may reflect patients experiencing very long waiting times.

The problem of waiting lists is one of the issues which has caused most concern at the Department of Health, and has been a consistent feature of recent health surveys, with some questions remaining unchanged for 5 years. The responses demonstrate how both concern and awareness among the general public have continued to grow, and confirm the existence of a relationship between the measures taken by different regional health services and the perception of relative improvements by respondents.

In December 2007 the Department of Health and the Consumer published its latest waiting list data. This includes the development of surgical waiting lists from December 2003 to June 2007. The chart shows that this has generally been positive, with average waiting times falling from 81 days in 2003 to 70 in 2007, although these actually increased in 2004 and 2005. The percentage of patients waiting more than six months also fell substantially. The first conclusion we can draw if we compare this chart with the two preceding ones is that public opinion is not arbitrary, as negative evaluations coincide with periods when waiting times were longer, and awareness of actions designed to remedy this problem has increased in line with improvements in the problem itself.

SURGICAL WAITING LIST FOR SPANISH NATIONAL HEALTH SERVICE
Development, December 2003–June 2007
Patients on structural waiting list, average waiting time and percentage over six months



(*) Estimated data for all Health Service waiting lists for selected processes; missing data for one Region (excluded from whole series).

Improvements, but not enough

According to the 2006 Ombudsman's Report, the number of complaints received regarding delays for surgery has fallen, possible thanks to the establishment of guaranteed times for scheduled surgery, in general between 90 and 180 days, depending on the region. However, it should be noted that for some health services and for certain procedures waiting times of greater than six months persist. For example, in Cantabria as of 31 December 2006, the average wait in the traumatology service at the Hospital de Laredo was 182.28 days, and it was 164.15 days at the Hospital Marqués de Valdecilla; in Catalonia, a guaranteed maximum waiting time of six months is still to be established for knee prosthesis procedures; in Aragon, the maxillofacial service of the Miguel Servet Hospital had delays of longer than six months; and in the Valencia Region some patients diverted to the private sector within the context of the established guarantee programme, have had to wait longer than eleven months for traumatology procedures[4].

With regard to visits to specialists and diagnostic tests and procedures, the Ombudsman stressed that there are still lengthy and, on occasion, unacceptable waiting times. And this is despite the growing importance and volume of such procedures. By way of example, one might mention a few of the instances identified in the report, such as the eleven-month wait for colonoscopy at the Complejo Asistencial in Burgos; ten months for an ultrasound prescribed at a health centre in Alcobendas, in the Madrid Region, or nine months for renal arteriography in Galicia.

Finally, the report stresses that there has been no significant progress with respect to the application of assisted reproduction techniques, and that as in previous years there were numerous complaints in this regard, where lengthy waiting lists, of several years in many health centres, mean that at times people do not receive the treatment to which they are entitled by law.

---

4. Agencia de Calidad del Sistema Nacional de Salud. *Sistema de información sobre listas de espera en el Sistema Nacional de Salud*. Situación a 30 June 2007. Indicadores resumen. At http://www.msc.es/estadEstudios/estadisticas/inforRecopilaciones/docs/listaPublicacion-07CI.pdf (visited 01 June 2008).

A defective information system

One area where the situation has not improved significantly since 2004 is the incomplete information provided by the regions with regard to waiting lists, attributable to a lack of cooperation and trust between regional and national institutions. For the most part, the information simply does not exist or, when it is published, the indicators are incomplete and there is no pre-established schedule. Comparison between regions is therefore impossible. An example of this unsatisfactory information is the use by the authorities of the «*average waiting time*» indicator which, in contrast with the study conducted by the Organization of Consumers and Service Users (OCU) does not identify the total time which patients have waited or will wait before receiving treatment, but instead measures how long patients have been on the waiting list at a given point in time. It is in response to this situation that Costas Lombardía has argued that waiting lists have been kidnapped by politicians. They are not managed but are instead used to partisan ends. Disinformation is absolute, and that is how everyone wants things to remain, making it impossible to measure the situation and, above all, preventing the comparisons between regions which politicians so abhor. A particularly significant example of disinformation in this regard is that of the Madrid Region, which since 2004 has used a calculation system which is different from that of other regions. In this system, the patient is not recorded as having joined the waiting list when the doctor prescribes the procedure, as happens in the rest of Spain, but only when he or she sees the anaesthetist. On average this takes 30 days. As a result, in December 2005 the Department of Health removed Madrid from national calculations of waiting lists.

Conclusions and recommendations

The 2006 Ombudsman's Report makes the following observations: firstly that, generally speaking, the health authorities have accepted the recommendations of the Ombudsman in this regard or have provided information regarding measures designed to reduce waiting times; secondly, that in some cases delays in the provision of treatment have been the result of problems caused by a shortage of certain medical specialists in the labour market; and thirdly, the existence of closed patient lists, with the resultant impact on patients, who have to attend health centres several times simply to obtain a medical appointment.

The OCU issued the following recommendations to Spain's regional governments in 2008: to create a waiting list information system which is public, transparent, and allows comparison; that all patients should be informed of their legal rights in the event that guaranteed waiting periods are not met; that the process of referring patients on from primary care doctors for diagnostic testing be speeded up and facilitated; and that better use be made of resources including, for example, evening shifts[5].

There must be transparency and easy access to public data sources, with the necessary safeguards, and there must also be a commitment to conducting studies to identify the answers to questions such as the following. What types of patient wait longest in terms of geography, socioeconomic conditions, and pathologies? What alternative measures are implemented when these waiting times become too long? Where are the main organizational bottlenecks? Are these solely the result of a lack of resources? Do delays pose a danger to life and/or aggravate clinical situations? We must, of course, bear in mind that waiting lists as such are unavoidable if we wish to continue to have everything, for everyone, free of charge at the point of treatment[6,7].

---

5. *Informe del Defensor del Pueblo a las Cortes Generales*. 2006. At www.defensordelpueblo.es (visited 01 June 2008).
6. Jiménez E. *Listas de espera de la sanidad pública: poca transparencia de las Comunidades Autónomas*. February 2008. At http://www.ocu.org/map/src/355934.htm (visited 01 June 2008).
7. del Llano J, Polanco C, García S. *¿Todo para todos y gratis?* El establecimiento de prioridades en el Sistema Nacional de Salud Español. Madrid: Ergon. 2004.

Panel Discussion

«How can we improve waiting lists?»

Marc Antoni Broggi

Vice President of the
Víctor Grífols i Lucas Foundation

The papers above were followed by a panel discussion designed to paint a more detailed picture of the situation and to explore further the difficulty of accepting waiting lists, on the one hand, and managing them, on the other. What follows is a brief summary of contributions which reflected the views of members of the public, of patients, of waiting list managers and of self-critical doctors.

Let us start with the views of the general public. This was provided by Juan del Llano, whose contribution is reproduced above. He is a specialist in Public Health at the Complutense University in Madrid for 20 years, and director of the Master's programme in Health Service Administration and Management at the Instituto de Formación Continuada and the Fundación Gaspar Casal in Madrid. His many works include a book with the eye-catching title, *¿Todo para todos y gratis?* [Everything for everyone and free?] Juan del Llano explained the opaque nature of health waiting lists in Spain and set out the case for increasing their transparency. He illustrated this by citing the fact that the Ombudsman revealed that in every region individual hospital waiting lists are too long and are closed, that is, are not known to the public. He showed how, despite promises and the injection of resources, members of the public do not perceive any improvement in the situation in any of the regions, either with regard to waiting times, or with respect to the transparency of the prioritization and management processes. Indeed, the issue of transparency is one of the most controversial aspects of our health system, and Juan del Llano ended by calling on politicians to become more involved in the search for solutions.

Next, we wanted to see how patients experienced or suffered the effects of this waiting and of the lack of transparency. For this, we turned to Ramón Bayés, Emeritus Professor of Psychology at the Autonomous University of Barcelona, who has dedicated many years and a great deal of energy to studying, explaining, writing about and arguing for the importance of the perception of time by those who are ill. This is a topic to which he returns in almost all of his books, and I would particularly recommend the chapter on waiting times in *Psicología del sufrimiento y de la muerte* [The psychology of suffering and death]. His observations have great bearing on both clinical activity and health management. All the contributions made it clear that waiting is a source of suffering which, while it is an unavoidable effect of the system, should be kept to an absolute minimum. We should be more aware of the suffering which waiting causes. Objective time, as measured by clocks and calendars, is one thing and the time which we perceive and suffer, while far more difficult to apprehend, is quite another. Ramón Bayés pointed out that, depending upon how we experience it, «a day may fly by, while an hour may be an unbearable eternity,» and the perception of the patient who is on a waiting list most closely resembles the second of these two situations. Suffering is related to feelings of vulnerability and lack of control, and the degree of suffering can therefore be reduced if patients are properly informed about how long they will have to wait and why; in other words, by telling patients the length of the waiting time and, if possible, explaining the reasons, we can help them to understand the wait and to tolerate it better. And to do this we must know how long the wait will be.

Of course, the management of waiting lists also has to be fair; that is, similar patients should not be treated differently, and nor should dissimilar patients be treated the same. To achieve this there must be both an awareness of the problems and a desire to introduce prioritization criteria which are objective, comparable and can be discussed openly. Mireia Espallargues was asked to illustrate how waiting lists could be improved in this regard. She is a specialist in Preventive Medicine and Public Health, and is assistant director of the Healthcare Quality Department of the Medical Research and Technology Evaluation Agency. She has contributed to numerous studies of clinical efficacy and variability, and perceived health, including one with which you should all be familiar, which looked at the prioritization of patients on waiting lists for hip, knee and cataract surgery.

This showed us that it was possible to develop a more useful strategy, based on greater rationality and equity, and going beyond the simple criterion of order of arrival, the only criterion which is explicit to date. There is an urgent need to promote prioritization, on the basis of need and expected benefit, which is transparent and consistent, thereby increasing the credibility of the system and the trust which the public have in it. In this regard, she clearly demonstrated that it is possible to design a prioritization system which has the support of managers, doctors, patients and families, and which is based on clinical criteria (seriousness of the pathology, pain, risk of development, etc.), functional ones (capacity to perform daily functions) and also on others which are more personal and social (caring for somebody else, or having to be cared for). By identifying different levels for each criterion and developing a simple, easy-to-manage scale, this can be useful for prioritization. In summary, developing systems to organize waiting lists is well worth the effort, and could transform this problem into something fairer and more credible for the general public, managers and doctors.

And it is precisely the doctors, among whose number I count myself, who should register today's proceedings and take note of the many publications which have recently appeared in this area. It is indeed the case that the bioethical revolution in medicine has sprung from the emergence of the principle of personal autonomy and the challenge this has posed for traditional paternalism; and that, by contrast, the introduction of equity has been accepted with less fuss and has been welcomed by doctors as an acceptable framework within which to improve quality and safety. But its organization has been left in the hands of the managers and, despite the many misunderstandings which have arisen and persist between management and doctors, the belief remains that managers should know what to do, and that management and doctors should restrict themselves to their own spheres. The waiting list was not the clear responsibility of either; patients were included on it by order of arrival, and it was then managed by the relevant health professional, or at most by the individual service, using ad hoc prioritization criteria which were generally clinical in nature: seriousness, poor progress, etc. However, these criteria were often distorted by others which were less acceptable and more personal. The situation was tolerated by the public so long as lists were short and easy to manage, but when they become more complex, the danger that doctors may find themselves unable to control them causes many to seek to wash their hands completely of a responsibility which they feel has become to much for them.

It is true that at times we appear to be paralyzed by the problem. We become disconcerted when the pressure rises excessively (whether through the media or otherwise), and want nothing to do with an issue which we do not regard as constituting a central part of our duties. For many of us, it does not form part of our vision of our professional role which we have acquired at medical school and from our elders; the responsibility is not ours but is, instead, that of a system which does not provide the necessary resources to deal with the issue. One might say that health professionals take refuge in what they understand as «their goals», or seek shelter in the intimacy of the clinical relationship. And they peer out from their offices or surgical theatres and see the shadows of management as an external imposition.

At the same time, everyone already believes the criteria they apply when including patients on the waiting list to be sufficiently solid, with the order being decided, naturally, on a «first come, first served» basis, prioritizing when deemed necessary, usually according to urgency or need, and sometimes according to the maximum expected benefit. However, because the criteria used are tacit and have not been set out in any protocol, or discussed and debated, there is a high degree of variability in practice between professionals (both with regard to inclusion and prioritization) and this means that discrimination, usually of a positive variety, can constantly be introduced. One clear example is the ease with which those who complain loudest are moved to the front of the queue. Such complaint often becomes a tacit prioritization criterion; doctors take such decisions themselves in order to avoid problems, but they also suffer from it (often reluctantly) when it is imposed on them from above on behalf of an influential person. This provides evidence of the scant mutual faith (of managers and doctors) in the fairness of the list. And this unfairness becomes a ubiquitous presence, accepted by health professionals, managers and politicians alike.

The PC («personal case», in my hospital) is defended by all, using fair means or foul. Perhaps it is a Mediterranean characteristic that this is seen not just as a privilege, but even as a right (an unwritten law, as Antigone would say) of the personal as against the public. By the same token, any VIP, politician or manager knows that he will not have to suffer from the equity which he so loudly proclaims for the rest. It does not concern him. And this is before we address the yet more complex issue of prioritizing between different waiting lists, and the way in which this is influenced by the scientific or professional «interest» in any given pathology. The injustice is compounded by the less than reasonable way in which politicians sometimes give emphasis to a particular procedure or action plan, in response to the latest press item or conference paper. All of these examples help to legitimate a degree of arbitrariness.

How can we root out, or at least weaken such widespread yet hidden practices? If we do not even consider what action to take, then we are unlikely to make much progress. One might argue that the first step is to seek to identify the grounds for a dialogue which is at once realistic and transparent. For example, it could be argued that the first stage is to agree that any action which cannot be discussed openly (because there are no grounds on which it can be defended) should not be taken. Can we say to our patients, can we justify to them, a situation where my colleague's father is treated before they are just because of this personal relationship? That the chair of the culture committee or the bishop should be treated first, regardless of other prioritization criteria? I tried in vain to include a clause in the ethics code of my hospital which read more or less as follows: «The duty of care towards those to whom we are joined by a particular relationship of affection or respect should not interfere with our duty towards other citizens.»

The problem of how to manage waiting lists in a more rational manner is one which remains to be solved. So far, our efforts have not been good enough, but this is something which must change. To achieve this, we must understand the reasons why better management is indeed necessary, we must accept that this is indeed a matter for us, we must believe that progress is possible, and we must work together to change attitudes in this area while remaining realistic about the pace of change.

As has been noted throughout the seminar, the time has come for doctors to be more aware of the need to become involved in the challenge of prioritizing between the patients we treat. And we need to be aware that this can be done in a more rational way than is the case at present. Indeed, failing to achieve this awareness does not relieve us of the obligation to prioritize, it just means that the way in which we do it is less satisfactory, with the result that we are unfair in our treatment of the population as a whole and may cause harm to specific patients. Here we must apply the same rational approach which we apply with such success to treating illness.

Doctors and managers must work together to address a shared problem: how to improve inclusion and prioritization criteria and make waiting lists more transparent and, as a result make the waiting time more tolerable (and shorter too, of course). And to achieve this we will require training, in order to overcome bad old habits and learn good new ones. In this regard, it is important to note, as Azucena Couceiro reminds us, that in these and other areas where doctors and managers work together, «a purely economic approach seriously demoralizes health professionals, and may destroy the ethical values which are so important to healthcare.» There is a danger that this will happen with respect to waiting lists, but this is a further reason why it is so important for doctors to become involved in managing the lists in which their patients are immersed. Our duty to protect our patients does not only apply when we have the patient before us, whether in the office, in the hospital bed, or during surgery. We must also protect them when they find themselves in the limbo of the waiting list. We should not become simple cost controllers and, when too much emphasis is placed on such considerations in the negotiation of our «targets», we should remember that our first loyalty is not to the institution but to other values which lie at the core of our profession. At the same time, we must accept that, whether we like it or not, we are distributors of resources and this is a task we must perform in a responsible, reasonable manner.

As professionals, we should also remember that management depends on justice just as science depends on truth (and art depends on honesty, as Rabelais would no doubt add). And we must remain aware, honestly aware, of all the effects of what we do if this is to be considered legitimate by society as a whole.

Publications

Bioethics Monographs:

20. *Ethical challenges of e-health*
19. *The person as the subject of medicine*
18. *Waiting lists. Can we improve them?*
17. *Individual Good and Common Good in Bioethics*
16. *Autonomy and Dependency in Old Age*
15. *Informed consent and cultural diversity*
14. *The issue of patient competence*
13. *Health information and the active participation of users*
12. *The management of nursing care*
11. *Los fines de la medicina (The Goals of Medicine)*
10. *Corresponsabilidad empresarial en el desarrollo sostenible (Corporate responsibility in sustainable development)*
9. *Ethics and sedation at the end of life*
8. *El uso racional de los medicamentos. Aspectos éticos (The rational use of medication: ethical aspects)*
7. *La gestión de los errores médicos (The management of medical errors)*
6. *The Ethics of medical communication*
5. *Problemas prácticos del consentimiento informado (Practical problems of informed consent)*
4. *Predictive medicine and discrimination*
3. *The pharmaceutical industry and medical progress*
2. *Ethical and scientific standards in research*
1. *Freedom and Health*

Reports of the Foundation:

4. *Las prestaciones privadas en las organizaciones sanitarias públicas* (Private services in public health organizations)
3. *Therapeutic Cloning: ethical, legal and scientific perspectives*
2. *An ethical framework for cooperation between companies and research centers*
1. *Social Perceptions of Biotechnology*

Ethical Questions:

1. *How to deal with repeat sexual offenders?*

For more information, visit: www.fundaciogrifols.org

FUNDACIÓ
VÍCTOR
GRÍFOLS
i LUCAS