Setting Priorities versus Managing Closures

What is the Ethically Most Sound Way of Handling Changes in the Health Care System?

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Acta Oncologica Vol. 38, No. 1, pp. 33–40, 1999

The answer to the question of the title depends on a number of circumstances, and I go through and comment on five of them. Then an attempt is made to keep some of these circumstances constant and vary others in order to highlight the importance of their ethical points of departure. The pros and cons of various choices are discussed and conclusions are suggested. To make further progress, the original question in the title is replaced by two new questions: under what conditions is managing closures the ethically soundest way of handling changes in the health-care system? And, under what conditions is setting priorities the ethically soundest way of handling changes in the health care system? Some tentative answers to these questions are outlined towards the end of this paper.

Received 15 July 1998
Accepted 21 August 1998

INTRODUCTION

The assumptions that (a) all changes in all health care systems can be dealt with either by setting priorities or by managing closures, and that (b) in all cases one of these options is ethically more sound than the other, are far from self-evident. Therefore, the answer to the question in the title is obvious, and can be stated in two plain words: 'It depends'. That could have been the end of this paper, but this answer clearly leads to another question: 'Depends on What?'

In very general terms, 'setting priorities' means saying 'no' to something (refusing treatment), saying 'no, not now but later' (delaying treatment), or perhaps saying 'no, not that expensive treatment' (providing less expensive treatments). The idea is that preventive, diagnostic or therapeutic methods, groups of diseases or patients are ranked in order of who is to be treated first or what is to be done first, and that the distribution of health care services, including the time of the health care staff, is to be based on criteria like health care needs (severity of disease), cost, effectiveness, etc.

According to Webster, 'closure' means an act of closing, the condition of being closed, or something that closes. In the present context, 'managing closures' includes decisions not to provide certain health care services at all, or not to certain groups, or only under certain conditions. It also includes the fact or the condition that certain health care services are not provided at all, or not to certain groups, or only certain conditions.

The problem of managing scarce resources is important, due to a number of well-known circumstances. Governments and hospital boards around the world are trying to cope with it in different ways. Health care professionals have experienced and expressed increasing frustration with their work situations. The approach advocated in New Zealand is more 'bottom up' than 'top down', it aims at improving the clinical decision-making. In other countries, such as Norway or Sweden, an approach that is more 'top down' than 'bottom up' has been chosen. Managing closures is closely linked to the 'top down' approach, but it is more complicated than that, as will be soon obvious.

IMPORANT CIRCUMSTANCES

In answering the question 'Depends on what?', it is possible to make a fresh start by clarifying the problem in the title, the problem of deciding what is the ethically soundest way of handling changes in the health care system. We can start by saying that the decision depends on the chosen ethical platform or starting point, which could be consequentialist, contractual, egalitarian, Kantian or any other type of deontological ethical theory.

ISSN 0284-186X

In fact, this is an important point that I shall need to come back to. Too many people seem to treat the expression 'the ethical point of view' as if there were only one, or as if all other ethical points of view except those endorsed by people themselves and their colleagues were unethical. We need to make explicit the ethical criteria of what constitutes harm and benefit, advantages and disadvantages, otherwise there is a great danger that we will be talking at cross-purposes.

The decision also depends on to which health care system one refers because systems differ in important and interesting ways concerning steering mechanisms, financing, (including patient co-payment, health care insurance and legislation), and what is included and excluded (dental care, for instance). They also differ in the extent to which there is private health care in the system, and the sort and extent of cooperation, if any, that exists between the private and public health care providers. For example, the health care system in Denmark is much more decentralized than in Norway; in Portugal, private health care plays a more important role than in Sweden.

To expand the previous point a little, in a research project entitled 'Europriorities', funded by the BioMed Program of the European Commission, researchers from five countries studied and compared the health care systems of several countries (Spain, Portugal, Germany, Denmark and Sweden). Their research is used as a basis for analysis of the norms and values taken for granted in the arguments and decisions concerning priorities in these countries. We have found differences between the health care systems of these countries that are more far-reaching in certain ways than one would expect from the literature.

The decision also depends on which changes in the health care system one has in mind. Do they concern the role of patient co-payment, whether parallel import of drugs should be allowed or prohibited, whether citizens are entitled to have a 'second opinion' or whether the public health care system should or should not pay for IVF? For some changes, managing closures may be the most ethically sound strategy, but for other types of changes, the solution may well be different. No doubt, there are some changes in the health care system that ought not to be handled by managing closures nor by priority setting, but, for instance, by adding more resources, restructuring the organization into a provider-purchaser system, or by changing the health insurance system.

For instance, one of the differences among the European systems compared in our study concerns the role of family doctors, GPs or their equivalents, as gatekeepers or guides. GPs or family doctors seem to function as gatekeepers to both specialists and hospitals (in some countries, like Spain), to hospitals, but not to specialists (in others, like Germany) or as guides (as in Sweden).

One possible change in a health care system intended to make it more cost-effective, could concern the gatekeeping functions. Here it seems that closures might, at least *prima facie*, be more effective and ethically sound than setting priorities. But if the changes mean, for instance, providing more resources to meet the needs of the chronically ill or dying patients, setting priorities might, at least *prima facie*, be a more promising and ethically sound approach.

Moreover, the decision depends on what we mean be 'setting priorities', what sorts of priorities and at which levels they are introduced, how, by whom and where they are introduced. What we mean by 'managing closures', what sorts of closures, at which levels they are introduced, and where in the system is also important.

Thus, the general characterization of the two alternatives mentioned earlier can be made more precise in a number of respects, some of which may well have a bearing on the question posed in the title of the present paper. If this is correct, the answer to the question posed in the title depends on at least these circumstances.

METHOD

But how does one go on from here? One possibility would be to keep several of these variables or circumstances constant and vary the others one at a time. The purpose of this exercise would be to see if and to what extent each variable changes the outcome. In view of space limitations, I cannot here go through all possible combinations to see what happens. I have to choose, and I have chosen to keep all the variables constant except the ethical starting points.

Let us limit our attention to those changes of the health care system that concern what Norman Daniels (1) and others have called 'macro decisions', which determine (a) what kind of health care services will exist in a society, (b) who will get them and on what basis, (c) who will deliver them, (d) how the burden of financing them will be distributed, and (e) how the power and control of these services will be distributed.

Right at the outset I would like to call attention to the fact that one cannot draw any far-reaching conclusions from this exercise, and in a way, that is the point of the whole exercise. A negative or skeptical result is also a result. No definite conclusions can be drawn until the result has been compared to the result of varying instead, for instance, the health care insurance system, and keeping the other variables, including the ethical premises, constant.

ETHICAL POINTS OF DEPARTURE

The ethical points of departure may be chosen in different ways, and there are pros and cons to be considered; it is not a question of picking and choosing more or less at random.

Four general and main types of choices include:

1. *The descriptive sociological approach*: This approach involves choosing value premises and norms that are widely accepted in one's own society, though it may not always be exactly clear how that society is to be delimited, especially in culturally or economically divided nations like South Africa, Yugoslavia, or Rwanda.
2. *The approach of professional codes*: This approach involves choosing value premises and norms that are stated in professional codes and declarations, like the Declaration of Geneva, the Helsinki Declaration or the Council of Europe convention on human rights and biomedicine.
3. *The approach of principles in governmental reports*: This approach involves choosing the principles used as starting points in some of the governmental white papers or commission reports on resource allocation and setting priorities.
4. *The ethical theory approach*: This approach involves choosing some ethical theory as a point of departure, for example, a theory focusing and elaborating on the moral importance of utility, rights, distributive justice, obligations, etc.

There are considerable variations within each group, but also important similarities, particularly in the two middle groups.

For example, certain basic ideas play an important role in the professional codes and declarations, like the four principles of Beauchamp & Childress (2). *Autonomy*, as a basis for informed consent, *beneficence*, as a basis for the samaritan duties of health care professionals, *non-maleficence*, as a basis for confidentiality, data protection and safety of patients and research subjects, and *justice*, as a basis for the distribution of scarce resources, are general principles with a wide range of applications. However, they can be interpreted in several ways, and can also be given different emphasis.

Likewise, there are several minor differences between the codes and guidelines proposed in the governmental reports on priority setting and resource allocation from Norway (3, 4), The Netherlands (5), Sweden (6, 7), Denmark (8) and New Zealand (9). But the reports all agree that differences in health care needs, expected utility and cost-effectiveness are relevant grounds for differential treatment.

More generally, they all agree on the importance of considering health care needs, the severity of the condition of the patients, the expected utility or health gain of the intervention as well as the costs of various interventions, and the ratio between cost and effectiveness. Moreover, social criteria include sex, race, profession, productivity, social and economic status, religious beliefs and view of life.

Nevertheless, these criteria can be interpreted in somewhat different ways, and they can also be ranked differently. This may, of course, affect the outcome, when the criteria are applied to specific cases.

The variety of approaches is perhaps particularly striking in the last group. However, sometimes the same decision or conclusion can be supported by very different ethical theories. It would be a mistake to conclude that any two people using two different ethical theories as a starting point must always come to different conclusions.

These four main approaches are not necessarily mutually exclusive, but they have somewhat different advantages and disadvantages that are worth further investigation. Some obvious points of comparison include: time/cost, relevance, precision, anchorage (acceptance basis), consistency, and the questions: in what society, and is the majority always right?

The time and cost of finding out which values and norms are actually accepted in a given society are considerable. Usually, the precision of the views (within and between groups) varies enormously. Moreover, people are not always consistent, and even if they were, it is unclear what conclusions can be drawn from such an empirical study.

We cannot conclude that the majority is always right without committing the naturalistic fallacy (10) or assuming what is to be proved. Besides, the question remains as to which values and norms of *which* society are relevant? The county council where we happen to live? Sweden? Europe? Or should we be thinking globally? The norms and values will certainly be very different in these different societies. But the main advantage, of course, is that the problems of anchorage can be regarded as handled satisfactorily, if the first alternative, and possibly also the second, is chosen.

If some of the other options are preferred, the situation is almost reversed. Time and cost are on their side. Both governmental reports and ethical theories are easily available. The precision and depth of intention of (at least) the latter is usually high. While the difficulty of applying them to the present problem should not be underestimated, it seems clear that the time and cost of these alternatives are much less; they are easier and quicker to apply. On the other hand, people do not always think along the lines of ethical theories, and then there is the problem of anchorage.

One approach to these problems is simply to try the various alternatives and see what their consequences will be under different conditions. Then an attempt should be made to discuss the pros and cons of these consequences openly and explicitly, rather than hiding the ethical criteria of what constitutes benefits and harms, and to relativize the discussion to the question of what is the ethically soundest way of handling changes in the health care system to the outcome of this analysis.

THE IMPORTANCE OF THE ETHICAL STARTING POINTS

To illustrate the importance of varying the ethical starting points as well as the type of changes, I will now (in an admittedly sketchy way) outline the consequences of certain ethical points for some types of changes and possible decisions in the health care system.

The question of alternative uses of resources is always relevant in this context. What health care services could we have got instead of spending the money in this or that particular way? Moreover, we cannot exclude the possibility that there are conditions, treatments and ethical criteria such that (a) the number of patients varies in each group, and (b) if these criteria are ranked differently, the outcome will be very different. Consider, for example, the following synopsis where the capital letters stand for different alternative treatments:

Condition	Leukaemia in children		Huntington's disease		Mild hypertension		Arthritis	
Treatment decision based on	A	B	C	D	E	F	G	H
1. Seriousness of disease								
2. Effectiveness measured in terms of five-year survival after treatment								
3. Effectiveness measured in terms of quality of life five years after treatment								
4. Cost per patient								
5. Cost per saved life								
6. Cost-effectiveness								

It is easy to see that the top contenders, according to the first criterion, will be at the bottom according to some of the others. Hence, the order in which criteria are ranked is of decisive importance.

Disagreement concerning what decision to take can be rooted in differences in value questions concerning means as well as ends. Different values can be attached to long-term survival, quality of life, cost per saved life, and so forth, both by different groups and by the same individual in different phases of his or her life. If 'five' in 'five-year survival' were replaced by 'two', for example, this might for some people change their ordering of these criteria.

A possible change to the health care system being debated in several countries at the present time, including my own, is whether a system of patients' rights should be introduced, for example, to the effect that every patient is entitled to a treatment within three months' time. (Is this closure or priority setting? In my view, it is closure with implications for priority setting, since it will affect the resources of the county councils or their equivalents.

The proposed change implies, as I understand it, that nobody should have to wait longer than three months for a treatment. If a patient's own hospital cannot provide the treatment within that time, he or she should be entitled to get it elsewhere, at the expense of the patients own county council. That is why such a system will affect the economy of the county councils.

Here the ethical platform obviously is of paramount importance. Let us suppose that the starting point is a theory of rights, which are construed as rights to claim access to health care services rather than to veto health care services offered. Then the decision whether or not to make the change might well be different from what it would be if the problem was approached from a utilitarian position.

The same holds if the problem involves a change in the rules for procuring organs for transplantation. Here the rights of patients to get information, opt in or opt out are natural starting points. If, however, we are considering how to allocate organs for transplantation, there are two problems to solve, given the scarcity of organs: whose needs are most urgent? And how can the organ be used optimally?

The latter problem is solved by allocating organs after HLA typing, size matching and avoiding transplanting young organs into old patients. This is a problem that seems easier to handle satisfactorily with priority setting, explicit or informal, than by managing closures. The practical result would certainly be different if, tempted by a theory of equal rights, we distributed organs on a lottery basis.

Consider a case where health care resources are so scarce that we have to make a tragic choice either to use the available resources on one person, badly hurt in a traffic accident, or to help a considerable number of people with minor hip problems. Given an egalitarian point of view, as defined by Nagel (11), the resources should go to the person badly hurt in a traffic accident. But according to classical utilitarian theory, including the assumption that many small utilities can be added to each other in a meaningful way, the choice might well be different.

Virtually everyone working with priority setting theoretically or practically agrees that justice is an important consideration when allocating health care resources, setting limits or making priorities. But the outcome may again be very different, depending on how justice is understood: as distribution of health care vouchers of equal amount within certain income ranges (12)? As distribution of health care services according to social merit, or according to health care needs? And what is the main goal, equal opportunity or equal outcome?

The interpretation and definition of 'justice' is not merely a semantic problem, since the choice of interpretation and definition will have consequences affecting segments of the population in different, positive and negative ways, furthering the interests of some at the expense of others. Hence the choice is not value-neutral.

REASONS FOR AND AGAINST SOME STARTING POINTS

Suppose we are not satisfied just to list a number of possible positions that others have taken, but that we also want—as I think we should—to look for arguments that some of these starting points are more fundamental than others. Then the following considerations might be helpful.

Utilitarians might argue that satisfying some basic principles of classic hedonistic utilitarianism or contemporary preference utilitarianism will, in fact, also satisfy whatever principle of justice we may endorse. Alternatively, or the other way round, they might argue that satisfying a particular principle of justice will, in the end, also lead to satisfaction of the basic principles of utilitarianism. However, these empirical claims are highly controversial, and it is hard to imagine how they can be proved.

For example, the empirical assumption that respecting individual autonomy will, in the long run, increase overall utility, is hard, if not impossible to prove. In the long run we will all be dead, and if the available evidence speaks against this empirical assumption at any time we want to test it, it is always possible to say: 'Wait a little longer—in two weeks, the hypothesis will be proven'. If it is not, this procedure can be repeated again and again—*ad infinitum*.

Another possibility is to start from a theory based on rights. These rights can be construed positively and negatively. They can be taken negatively as the right to refuse health care services offered, including to veto what others want to do to your body, or positively as the right to claim certain health care services. The central problem in both cases, however, is to justify these rights. Here we are driven back, in my view, to a theory of distributive justice.

I agree with Norman Daniels (1) that health care, both preventive and acute, has a crucial effect on the equality of opportunity. This is an empirical assumption, which, in principle, is testable. To this we may add a principle guaranteeing equality of opportunity, which should underlie the distribution of health care services. This is, of course, a normative assumption. An alternative, stronger assumption is to demand equality of outcome, as Robert Veatch has suggested (13).

In Daniels' view, the normal opportunity range for a given society is the array of life planes reasonable persons in it are likely to construct for themselves. Quite rightly, he adds that the share of normal opportunity open to an individual is also determined in a fundamental way by his talents and skills. However, his conclusion is that we should use impairment of the normal range of opportunity as a fairly crude measure of the relative importance of health care needs at the macro level (1).

GOALS AND QUALITY OF INFORMATION

Two other problems are perhaps more important from an ethical point of view than the choice between managing closures and setting priorities:

1. What type, amount and quality of information is needed to make informed decisions on allocating resources in health care? and
2. What are the goals of medicine and the health care system?

Answers to both questions are necessary to provide a secure foundation for the discussion of whether managing closures or priority setting is preferable from an ethical point of view, and under what conditions.

The importance of the first problem is clearly that if decisions are taken on the basis of incorrect or misleading information, many people might be harmed and wronged. However, it is not easy to devise a test to decide whether the information in a particular case is adequate for decisions-making. Whether certain information is misleading or not sometimes also depends on what those who receive the information know or take for granted. The problem is tricky, because decisions are always based on information that is more or less incomplete and uncertain.

In any case, it should be emphasized that the information required varies with the problem at hand. Here it is essential to distinguish between problems on at least two different levels, the clinical level and the political-administrative level, a point made by the Swedish governmental commission (6, 7). For example, at the latter level, information concerning health care needs in the population, effectiveness and efficiency of various methods of treatment, waiting lines, risks of complication and negative side effects is necessary. At the clinical level, the important information concerns the situation of the individual patient, the various treatment alternatives available at the hospital or in the country, the effects of diagnostic and therapeutic interventions on the particular patient, and individualized risk perception and risk management.

To be more specific, we need to identify important problems, trace the relations between them, find relevant and reliable medical data, including criteria for the use of diagnostic and therapeutic methods (inclusion and exclusion criteria), survey alternative methods and their effectiveness, identify the number of patients concerned, and perform risk assessment, as outlined by the Norwegian governmental commission. Moreover, it is necessary to know something about the hopes and fears of the population, and the effects of medical interventions on them.

In other words, one must try to describe and analyse the attitudes of the population or the patient groups concerned, in addition to identifying and developing methods of measuring the costs of intervention (and, of course, of non-intervention). All this information must be interpreted and synthesized. Uncertainties and lack of knowledge, particularly concerning the effects from a longer-term perspective, are important to keep in mind.

The goals of medicine and the health care system are obviously crucially important in this context, since the weighing of the pros and cons of various alternatives must be related to these goals in order to avoid talking at cross-purposes.

The discussion of these important issues has recently been renewed by The Hastings Center in a report (14), where the main tendency is to move ‘away from curing and high technology to caring with emphasis on public health and disease prevention’. In this report, the goals of medicine are stated in the following four general sentences, which are later clarified and commented on:

- The prevention of disease and injury and the promotion and maintenance of health.
- Relief of pain and suffering caused by maladies.
- The care and cure of those with a malady, and the care of those who cannot be cured.
- The avoidance of premature death and the pursuit of a peaceful death.

These ideas are far from uncontroversial, but they do have important implications for priority setting and resource allocation in health care.

However, the goals of medicine and the health care system are not identical. The latter have political dimensions as well, and include considerations concerning access, social and geographic equality (justice between regions), health care on equal conditions (justice between sexes, generations and races) as well as democracy and user influence (participation in decision-making).

SOME ASSUMPTIONS

Thus, answering the question in the title of my paper cannot be done without making a number of assumptions explicit.

I am assuming, then that our focus is not a market-oriented health care system such as there is in the USA (where a large sector of the population is not covered by health care insurance), but rather a health care system in a welfare state, such as exists in the Scandinavian countries. This system of health care services is essentially financed by taxes. Here, the bargaining power of the doctors and insurance companies is considerably less than in the German health care system for example, and private health care is very limited.

I am also assuming that our focus is on macro decisions affecting at least one of the five types of changes mentioned earlier. For instance, these decisions include whether certain therapeutic methods should be preferred to others, whether particular groups of patients should receive a larger (or smaller) share of the resources, whether the structure of the system should be changed by reducing the number of small hospitals (a very hot topic in my country at the present time), or whether the gate-keeping system should be different.

A TENTATIVE ANSWER

A very reasonable principle is that individuals or groups should be treated differently only if there is a morally relevant difference between them. If no such difference can be found, they should be entitled to equal treatment. The adherents of many different ethical platforms accept this as a general starting point, though they may have somewhat different criteria and ideas about what differences are relevant.

Given this starting point, there is an obvious problem with closures, more important at some levels than at others. There can be distressing discrepancy between the benefits of closures, as described in leaflets from hospital management, and their reality, as experienced by health care professionals working in hospitals. The problem is also, and perhaps above all, that closures must be stated in general terms, based on lists or criteria singling out groups of people (for example, people of a certain age or with certain diagnoses). However, variations within any of these groups may be just as important and worthy of consideration as variations between groups.

Two important considerations in this context are obviously flexibility and equality (equity). The latter might speak for closures, provided that these are based on what is generally agreed to be the right categories. If not, closures might be counterproductive. Consider, for example, closures for self-inflicted injuries or for certain health care services to people of a particular age. If need rather than age is really the central notion, however, and health care needs vary within age groups, then flexibility and good judgement become important, and setting priorities on the basis of health care needs is the ethically soundest option.

For the kinds of changes discussed here, the crucial question becomes whether managing closures rather than priority setting—or vice versa—facilitates fair equality of opportunity (provided we accept this as our overriding concern), or if they are indifferent or indistinguishable in this respect.

Perhaps progress can be made by replacing the original question in the title with two others:

1. Under what conditions, if any, is setting priorities the ethically soundest way of handling changes in the health care system?
2. Under what conditions, if any, is managing closures the ethically soundest way of handling changes in the health care system?

Answers to both questions would have to be based on several assumptions, concerning the type of changes, the ethical starting point, the characteristics of the health care system in question, etc. Even so, it would be a step forward if some conditions could be identified under one of the competing strategies, and a decision made as to which strategy, given certain assumptions, ought to be preferred to the others.

Let us assume, then, to narrow down the possibilities, that a theory of distributive justice like the one suggested by Norman Daniels (1) is used as an ethical point of departure, that we provisionally accept the goals of medicine proposed by the Hastings Institute (14), and that we focus on problems of welfare states like those in the Scandinavian countries (the resource allocation problems of developing countries differ in important respects). Then a tentative answer to the question posed in the title of this paper can be outlined as follows.

The conditions under which *managing closures* seems to have several advantages include:

- Resource allocation on the political-administrative level (which obviously will have an impact on clinical decision-making, at least indirectly); in particular when
- The changes concern financing (where the money comes from), expenditure (where the money goes), whether and on what conditions private health care is allowed, power and control of the system;
- Decisions concern patient co-payment, the benefits of the health care insurance system, thresholds (such as those in the Swedish dental insurance system) or the rules of cooperation between private and non-private health care providers; and
- The preferences of the population or the concerned groups of patients are uniform, stable or easily predictable.

On the other hand, *priority setting* in the sense described earlier is preferable to managing closures when:

- We are concerned with clinical rather than political-administrative decision-making;
- The basic categories of the theory of distributive justice (including health care needs, normal functioning, normal range of opportunities, etc.) are not uncontested or not so precise that they can be applied in a mechanical way;
- What the population or the concerned groups of patients want is unclear, or varies between and within different groups in society or changes in ways that are difficult to predict; and
- Flexibility and ability to take into consideration the circumstances of particular cases or situations is important.

CONCLUDING REMARKS

First of all, I want to stress the highly tentative character of some of these suggestions. It also seems fair to warn against the belief that problems will be solved once and for all by criteria, guidelines, and even more closures, which (as I understand them) are less flexible than criteria and guidelines.

Especially at the clinical level, quick, discretionary judgments are impossible to avoid, and they must be left to the professional responsibility of the health care staff. However, I personally believe that a great deal can be done within the various specialist organizations to prepare manuals and maintain ongoing discussion of their content. This discussion should include constant upgrading and evaluation of the manuals, in light of the results of medical technology assessment.

From a theoretical point of view, in spite of the considerable efforts already made (1, 15, 16), more work needs to be done toward making explicit the underlying conceptions of health, disease, normality and the goals of medicine and health care, as well as on clarifying key concepts such as health care need, normal range of opportunities, etc.

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