Discrepancy between health care rationing at the bedside and policy level

Emil Persson, David Andersson, Lovisa Back, Thomas Davidson, Emma Johannisson, Gustav Tinghöög

Department of Management and Engineering, Division of Economics, Linköping University, Linköping, Sweden, & The National Center for Priority Setting in Health Care, Department of Medical and Health Sciences, Linköping University, Linköping, Sweden

Preliminary and incomplete – please don’t cite or circulate without permission

Abstract

Background. Whether doctors at the bedside level should be engaged in health-care rationing is a controversial topic that has spurred much debate. From an empirical point of view, a key issue is whether there exists a behavioral difference between rationing at the bedside and policy level. Psychological theory suggests that we should indeed expect such a difference, but existing empirical evidence is inconclusive. Objective. To explore whether rationing decisions taken at the bedside level are different from rationing decisions taken at the policy level. Method. Behavioral experiment where participants (n=573) made rationing decisions in hypothetical scenarios. Participants (medical and non-medical students) were randomly assigned to either a bedside or a policy condition. Each scenario involved one decision, concerning either a life-saving medical treatment or a quality-of-life improving treatment. All scenarios were identical across the bedside and policy condition except for the level of decision making. Results. We found a discrepancy between health-care rationing at policy and bedside level for scenarios involving life-saving decisions, where subjects rationed treatments to a greater extent at the policy level compared to bedside level (35.6% vs. 29.3%, p<0.001). The effect was larger for medical students compared to other students. Follow-up questions showed that bedside rationing was more emotionally burdensome than rationing at the policy level, indicating that psychological factors likely play a key role in explaining the observed behavioral differences. We found no difference in rationing between bedside and policy level for quality-of-life improving treatments (54.6% vs, 55.7%, p=0.507). Conclusions. Our results indicate a robust “bedside effect” in the life-saving domain of health-care rationing decisions. This has implications for the design of fair and efficient priority-setting policies in health care. Key words: health-care rationing; individuals and groups; decision making; identifiability; experiment.
Introduction

Medical decision makers at all levels in publicly funded health care systems are expected to ensure both equity and efficiency through fair rationing. Health-care rationing requires medical decision makers to limit access to care even in cases where the treatment withheld may benefit the patient. It has been argued that rationing of this kind is especially uncomfortable for medical doctors at the bedside level since it entails a violation of the common medical norm of always doing what is best for the patient, even whilst pursuing societal interest ahead of the interest of the individual patient (1). Whether bedside rationing should in fact be considered at all is a controversial topic that has spurred much debate (2-7). Empirically, a key issue is whether rationing decisions taken at the bedside level will indeed be different from rationing decisions taken at other levels of the health care system. This is still an open empirical question, which we address in the current paper.

In a seminal study, Redelmeier and Tversky (8) found substantial differences between medical decisions taken on behalf of a single patient and a group of patients. Physicians were more likely to order an expensive blood test that might detect a rare, treatable, condition if they were deciding on behalf of a single patient as opposed to a group of comparable patients. In the same paper they also found that laypeople (undergraduate students) were more likely to recommend a risky treatment for an incurable blood condition to a single patient than to a group of patients. However, DeKay et al. (9) were unable to replicate this latter finding. Moreover, they found that the information in the scenario used by Redelmeier and Tversky differed between bedside and policy level and therefore modified it. Using a revised version of the scenario, they performed a new test that resulted in a higher proportion of recommendations to the patient group compared to the individual patients, i.e., the opposite result to Redelmeier and Tversky. Thus, existing empirical evidence is inconclusive and the behavioral discrepancy between health care rationing at the bedside and policy level is still not fully understood.

Many psychological theories argue that emotions and affect are important components of decision making (10-12), and, moreover, that different mental processes may be involved when judging a specific target (an individual) compared to judging a general target (a group) (13). Both of these aspects are highly relevant to decision making in health care. Rationing at the bedside level is arguably more difficult and emotionally burdensome than rationing at the policy level, primarily because the physician meets the patient face-to-face. The negative consequences of denying care to the patient becomes very real and tangible to the physician making decisions at the bedside. On the contrary, rationing at the policy level concerns denying care to a group of patients, meaning that the negative consequences pertain to a statistical and anonymous patient rather than a single, identified patient. This relates to what is known as the identifiable victim effect in psychology, i.e., that individual decision makers are more willing to help individuals that are presented as identified rather than anonymous victims (12, 14-18). This a robust empirical finding in general helping dilemmas, but to date not thoroughly explored in the context of medical decision making.

The purpose of this study is to explore (i) whether and to what extent rationing decisions taken at the bedside level are different from rationing decisions taken at the policy level, and
(ii) whether this difference is more pronounced for life-saving decisions as opposed to
decisions concerning quality-of-life improvements. To this end, we conduct a large-scale
behavioral experiment where both medical and non-medical students make a series of
rationing decisions either at the bedside level or at the policy level. We hypothesized that
rationing decisions would be less prevalent in the bedside condition (Hypothesis 1) and for
life-saving scenarios (Hypothesis 2), due to the emotional nature of the decision. Our study
extends previous research and contributes with new knowledge about the discrepancy
between medical decision making at the bedside and policy level. We collected a large
number of responses from both medical and non-medical students, which is important from a
methodological perspective since previous studies focused on either physicians or laypeople
but did not include both in the same study. Moreover, we focus on rationing decisions
(denying care) while previous studies focused on medical decisions framed as priority setting
in the context of providing medical care. This is an important distinction in light of the choice
framing literature, with the key finding that framing equivalent decision-problems as losses
rather than gains often affect people’s choices (19). It is therefore probable that a rationing
frame evokes stronger negative emotions in individuals, especially for decisions taken at the
bedside level.

Methods

Participants

We conducted a randomized experiment at Linköping University during March 2015,
involving both medical students and students from other undergraduate programs. In total,
573 subjects participated in the experiment. Mean age among respondents was 23.6 years and
52.4% were women. Medical students represented 54.3% of subjects in the sample. About
half of the medical students in the sample (47.7%) had studied more than six semesters,
meaning they have some experience from clinical practice. As shown in Table 1, there were
no differences in the background characteristics between conditions.

<table>
<thead>
<tr>
<th></th>
<th>Bedside</th>
<th>Policy</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>289</td>
<td>284</td>
<td></td>
</tr>
<tr>
<td>Female, n (%)</td>
<td>152 (52.6%)</td>
<td>148 (52.1%)</td>
<td>0.7686</td>
</tr>
<tr>
<td>Age, mean (SD)</td>
<td>23.7 (3.66)</td>
<td>23.5 (3.24)</td>
<td>0.7127</td>
</tr>
<tr>
<td>Medical Students, n (%)</td>
<td>157 (54.3%)</td>
<td>154 (54.2%)</td>
<td>0.9809</td>
</tr>
</tbody>
</table>

Note: Subjects were randomly assigned to either the Bedside or Policy condition.

Materials

Subjects were recruited on campus at Linköping University and completed a pen-and-paper
questionnaire containing a series of rationing scenarios. We implemented a 2×2 experimental
design, with subjects randomly assigned to either a bedside or a policy condition (between-
subject variation) that contained twelve rationing scenarios. Each scenario involved one
decision, concerning either a life-saving medical treatment or a quality-of-life (QoL)
improving medical treatment (within-subject variation). All scenarios were identical across the bedside and policy condition except for the level of decision making: In the policy condition, subjects took the role of head of department and made decisions regarding a patient based upon group statistics. At bedside level, subjects instead took the role of a physician and made decisions regarding a single patient who was presented with name and picture. Scenarios were presented in two fixed orders to control for potential order effects. At the end of the experiment, subjects were asked about age, gender, and how emotionally burdensome they experienced the scenarios.

Three of the scenarios used in the experiment are presented in Figure 1 (all scenarios can be found in Appendix). Each rationing scenario is described in three paragraphs and at the end the respondent makes his or her decision whether to offer a particular treatment, which is given at the hospital level in the policy condition and to a single, identified, patient in the bedside condition. The first paragraph introduces the situation, and respondents are reminded of their role: “You are a physician,” or “You are the head of a department.” The second paragraph describes briefly the disease treatment based on medical and economical aspects, and this information is identical between the decision-making contexts. The last paragraph describes the consequences of refusing treatment.

Five of the rationing scenarios involved life-saving treatments and six involved QoL-improving treatments. The five life-saving treatments covered different disease areas, e.g. various forms of cancer, prenatal births, and heart disease. The five QoL-improving treatments covered treatments for Alzheimer, diabetes, hearing impairment, hyperhidrosis, growth disorder and chronic obstructive pulmonary disease (COPD). In order to make comparisons with previous studies that explored differences in medical decision making for individuals and groups, we also included a twelfth scenario. This scenario was a direct replication of the scenario used in De Kay et al. (9), which is the revised version of the scenario developed by Redelmeier and Tversky (8). The scenarios presented as examples in Figure 1 covers one life-saving treatment, one QoL-improving treatment, and the revised version of the scenario used by Redelmeier and Tversky about an incurable blood condition (9).

Analysis

Responses were coded 1 for recommend medication and 0 for recommend against medication for the blood disease scenario. All other scenarios were coded 0 for provide treatment (“Yes”) and 1 for do not provide treatment (“No”). Our main dependent variable is the proportion of rationing decisions calculated at the level of the individual, i.e. the rate at which individuals choose do not provide treatment. We use two-sided t-tests in all our comparisons (across groups, scenarios, and conditions). The effects of age and gender are investigated using regression analysis, and we test for order effects by comparing the proportion of rationing decisions (all scenarios) across the two orders for the bedside condition, the policy condition, and, finally, for both conditions jointly. Subjects also indicated (at the end of the experiment) how emotionally burdensome they experienced the scenarios. These answers were recorded on a six-point Likert scale, ranging from 1 (“not at all”) to 6 (“highly burdensome”).
The heart disease scenario (life-saving)

**Policy level**
You are head of department in a hospital. You will decide whether the hospital should introduce an alternative form of treatment for patients who are born with an incurable heart disease.

With standard treatment children with this incurable heart disease survive to their teenage years. The alternative treatment prolongs the life of a child by ten more years. This form of treatment costs 500 000 SEK (=USD 62,500) per year more than the standard.

The alternative is to let the money fund other treatments in the hospital.

Do you choose to introduce the alternative form of treatment?
- Yes
- No

**Bedside level**
You are a doctor. Your patient Signe is 1 year old and suffers from a congenital and incurable heart disease. Signe’s parents come to you and tell you that they have heard about an alternative form of treatment. The parents ask you to give the treatment to their daughter.

With standard treatment children with this incurable heart disease survive to their teenage years. The alternative treatment prolongs the life of a child by ten more years. This form of treatment costs 500 000 SEK (=USD 62,500) per year more than the standard.

The alternative is to let the money fund other treatments in the hospital.

Do you choose to give Signe the alternative treatment?
- Yes
- No

The diabetes scenario (QoL-improving)

**Policy level**
You are head of department in a hospital. You will decide whether the department should provide an insulin pump to all patients with diabetes type I.

With an insulin pump, the patient can live a more comfortable and flexible life. In the current situation insulin pumps are only offered to patients where the injection treatment is problematic. The insulin pump costs 40 000 SEK (=USD 5 000). In addition, there is a cost of 25 000 SEK (=USD 3,125) more per patient per year than standard treatment with injections.

The alternative is that the money is used to fund other treatments in the hospital.

Do you choose to offer insulin pumps to patients with type I diabetes?
- Yes
- No

**Bedside level**
You are a doctor. Your patient Lena is 42 years old and has diabetes type I. She is in good health and has stable blood sugar levels. Lena comes to you and asks about getting an insulin pump.

With an insulin pump, the patient can live a more comfortable and flexible life. In the current situation insulin pumps are only offered to patients where the injection treatment is problematic. The insulin pump costs 40 000 SEK (=USD 5 000). In addition, there is a cost of 25 000 SEK (=USD 3,125) more per patient per year than standard treatment with injections.

The alternative is that the money is used to fund other treatments in the hospital.

Do you choose to give Lena an insulin pump?
- Yes
- No

The blood disease scenario (9)

**Policy level**
Some middle aged women have a particular incurable blood condition. With treatment they are expected to live between 5 and 10 years without symptoms, and then die.

Suppose there is a medication that could be added to their therapy that has been shown to be of benefit, although sometimes it makes things worse. With the additional medication it is expected that 85% of women with this condition will gain 2 more years of life, and 15% of the women will lose 4 years of life.

If you were asked to give your opinion which treatment would you recommend in this situation?
- Strongly recommend that they take the medication
- Suggest that they take the medication
- Suggest that they not take the medication
- Strongly recommend that they not take the medication

**Bedside level**
L.M. is a middle aged woman who has a particular incurable blood condition. With treatment she is expected to live between 5 and 10 years without symptoms, and then die.

Suppose there is a medication that could be added to her therapy that has been shown to be of benefit, although sometimes it makes things worse. With the additional medication it is expected that 85% of women with this condition will gain 2 more years of life, and 15% of the women will lose 4 years of life.

If you were asked to give your opinion, how strongly would you recommend the medication to L.M. in this situation?
- Strongly recommend that she take the medication
- Suggest that she take the medication
- Suggest that she not take the medication
- Strongly recommend that she not take the medication

Figure 1. Three rationing scenarios used in the experiment.
Results

We begin by reporting the results for the incurable blood condition, previously used by Redelmeier & Tversky (8) and Dekay et al. (9). A higher proportion of subjects recommended care at the policy level compared to bedside level (56 % vs. 51 %) in our replication, but the difference is not statistically significant (p=0.227). This result is different from Redelmeir and Tversky but in line with DeKay et al.

Figure 2 shows our main results. We found no overall difference in the mean rate of rationing between bedside and policy level (Mean Rate: 0.438 vs. 0.459, p=0.110). When the effect was separated by type of scenario (QoL vs. life-saving), we found a significant difference for life-saving treatments (Mean Rate: 0.293 vs. 0.356 p<0.001) but not for QoL-improving treatments (Mean Rate: 0.557 vs. 0.546, p= 0.507). This partly confirms Hypothesis 1. We can also see in the figure that QoL-improvements are rationed more frequently than life-saving treatments, both at the bedside at policy level, which is clearly in line with Hypothesis 2. Taken together, subjects were much more reluctant to deny life-saving treatments at the bedside level compared to at the policy level. A potential reason for this effect could be the emotional nature of the decision. To explore this possibility, we had included a follow-up question at the end of the experiment, asking subjects to indicate (on a six-point Likert scale) how emotionally burdensome they experienced the scenarios. Indeed, compared to subjects in the policy condition, subjects in the bedside condition experienced the scenarios as significantly more emotionally burdensome (3.565 vs 3.366, p=0.039).

Figure 2. Health care rationing decisions at the bedside and policy level.

Table 2 presents a comparison between medical students and non-medical students. Medical students were more likely to ration care compared to non-medical students (Mean Rate: 0.466 vs. 0.428 p=0.006). The effect was greatest for scenarios involving life-saving treatments, where the difference in the mean rate of rationing decisions between medical and non-
medical students was 5.0 percentage points (p=0.008). Interestingly, the difference between bedside and policy conditions is larger among medical students (Difference Mean Rate: 0.035, p=0.029) than among non-medical students (Difference Mean Rate: 0.006, p=0.800), and the largest effect was found among medical students who had some clinical experience (Difference Mean Rate: 0.113, p=0.001, for life-saving scenarios). Medical students are thus to a greater extent influenced by the level of decision making, an effect that is mainly driven by the difference in rationing decisions taken at the policy level, where medical students are more likely than non-medical students to ration care (0.483 vs. 0.431, p=0.008).

Table 2. Rationing decisions, by medical students and other students

<table>
<thead>
<tr>
<th></th>
<th>Medical students n=311</th>
<th>Non-medical students n=262</th>
<th>diff</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (Bedside and policy):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All scenarios</td>
<td>0.466</td>
<td>0.428</td>
<td>0.038</td>
<td>0.006</td>
</tr>
<tr>
<td>Life-saving scenarios</td>
<td>0.347</td>
<td>0.296</td>
<td>0.050</td>
<td>0.008</td>
</tr>
<tr>
<td>QoL-improving scenarios</td>
<td>0.564</td>
<td>0.537</td>
<td>0.027</td>
<td>0.126</td>
</tr>
<tr>
<td>Bedside:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All scenarios</td>
<td>0.448</td>
<td>0.425</td>
<td>0.024</td>
<td>0.214</td>
</tr>
<tr>
<td>Life-saving scenarios</td>
<td>0.305</td>
<td>0.278</td>
<td>0.027</td>
<td>0.272</td>
</tr>
<tr>
<td>QoL-improving scenarios</td>
<td>0.566</td>
<td>0.547</td>
<td>0.019</td>
<td>0.435</td>
</tr>
<tr>
<td>Policy:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All scenarios</td>
<td>0.483</td>
<td>0.431</td>
<td>0.053</td>
<td>0.008</td>
</tr>
<tr>
<td>Life-saving scenarios</td>
<td>0.389</td>
<td>0.315</td>
<td>0.074</td>
<td>0.008</td>
</tr>
<tr>
<td>QoL-improving scenarios</td>
<td>0.562</td>
<td>0.527</td>
<td>0.035</td>
<td>0.163</td>
</tr>
</tbody>
</table>

Note: The table shows the proportion of decisions that were in favor of rationing (denying) medical care.

To further explore the descriptive results, we conducted regression analyses on rationing decisions controlling for age and gender. Results are presented in Table 3. In line with what we could see in Figure 2, there is no difference between policy and bedside level when looking at all scenarios. There is however a significant effect when looking at life-saving scenarios only, where subject in the bedside condition are 5.9 percentage points less likely to deny care to their patients (p=0.002). There is no such difference for quality of life improving treatments. We can also see that medical students were more likely to ration care, especially for life-saving scenarios where the estimated difference between medical and non-medical students is 6.2 percentage points (p=0.002). Interestingly, women were significantly more reluctant to ration care, primarily in life-saving scenarios where the difference to men amounted to 3.9 percentage points (p=0.040). Age did not affect decisions. We also tested for order effects but found no differences in rationing decisions between the two orders at conventional levels of significance.
Table 3. OLS regression on rationing decisions

<table>
<thead>
<tr>
<th>Level</th>
<th>QoL-Improving scenarios</th>
<th>Life-saving scenarios</th>
<th>All scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Est  p-value</td>
<td>Est  p-value</td>
<td>Est  p-value</td>
</tr>
<tr>
<td>Bedside</td>
<td>0.006 0.715</td>
<td>-0.059 0.002</td>
<td>-0.022 0.098</td>
</tr>
<tr>
<td>Policy</td>
<td>REF</td>
<td>REF</td>
<td>REF</td>
</tr>
<tr>
<td>Education</td>
<td>Medical 0.033 0.070</td>
<td>0.062 0.001</td>
<td>0.046 0.001</td>
</tr>
<tr>
<td></td>
<td>Non-medical REF</td>
<td>REF</td>
<td>REF</td>
</tr>
<tr>
<td>Gender</td>
<td>Female -0.022 0.218</td>
<td>-0.039 0.040</td>
<td>-0.030 0.031</td>
</tr>
<tr>
<td></td>
<td>Male REF</td>
<td>REF</td>
<td>REF</td>
</tr>
<tr>
<td>Age</td>
<td>-0.002 0.447</td>
<td>-0.002 0.576</td>
<td>-0.002 0.382</td>
</tr>
</tbody>
</table>

Note: The dependent variable is the rate at which individuals deny care (each decision in a scenario is coded 0 for provide treatment and 1 for do not provide treatment).

Discussion

It is important to understand the behavioral differences in rationing decisions taken at different levels in the health care system. A bias in decision making at one level or the other has implications for patient outcomes, and thus for the design of fair and efficient priority-setting policies in health care. We found a discrepancy between health care rationing at policy and bedside level for scenarios involving life-saving decisions, where subjects rationed treatments to a greater extent at the policy level compared to bedside level. The effect was larger for medical students than for non-medical students. Follow-up questions indicated that bedside rationing was emotionally burdensome, which is in line with psychological mechanisms believed to influence behavior in helping dilemmas. In contrast to Redelmeir and Tversky (8) we did not find a difference between decisions at policy and bedside level for the blood disease scenario, a finding which is in line with the follow-up study by DeKay et al. (9).

The fact that we couldn’t replicate Redelmeir and Tversky and moreover that we found no difference in rationing decisions between bedside and policy level for QoL-improving treatments suggest that behavioral differences are smaller than previously thought. Nevertheless, as already mentioned we did find an effect for life-saving, where there was a robust 6.6 percentage-point gap in rationing decisions between bedside and policy level. This result is in line with the hypotheses that bedside rationing is more demanding due to the emotional nature of the decision. An interesting avenue for future research is thus to explore this mechanism in greater detail, building on the identifiable victim effect much discussed in the psychological literature.

Taken together, our results indicate a robust “bedside effect” in the life-saving domain of health care rationing decisions. Interestingly, this effect was larger among medical students compared to other undergraduate students. We did not have a clear hypothesis for this comparison. On the one hand, would have expected medical students to be less influenced by
the experimental manipulation, due to their greater experience in medical and clinical judgment. On the other hand, however, medical students’ current clinical experience (from their training) has most likely concerned bedside decision making, meaning that the bedside condition in the experiment should possibly exert a stronger influence on them compared to other students. This would be in line with the finding that medical students primed to think about the importance of the Hippocratic Oath (which embodies a duty to think first-handed about their own patients) were more altruistic toward patients but also showed less concern for efficiency and third-party payers’ provision costs (20). Looking at our results in more detail, the difference between medical and non-medical students is mainly driven by decisions at the policy level, where medical students to a greater extent rationed medical treatment. One possible interpretation is that medical students were indeed prepared to ration care (they presumably knew the importance of doing so to society at large), but faced conflicting obligations when the decision had to be taken at the bedside rather than policy level. The main takeaway in this respect, however, is the fact that the “bedside effect” prevailed in the sample of medical students (future clinicians), which again suggests that the effect is robust and likely to influence real life medical decision making.

Our study extends previous research on priority setting, using a randomized experiment on rationing decisions in hypothetical scenarios. This type of design typically has high internal validity, and the large sample size ensures that our statistical tests are high-powered based on effect sizes observed in previous studies. The most obvious limitation with this research paradigm is the hypothetical nature of decisions. Although the different scenarios used in our experiment covered a variety of conditions spanning a range of medical domains, it is not certain that our results would extend to actual health care decision making. Moreover, whereas we make a methodological contribution by comparing medical and non-medical students in the same study, from an external-validity point of view it would arguably have been better to use medical professionals or practicing physicians experienced in actual decision making at bedside or policy level.

Traditionally, many medical doctors and ethicists have argued that it is morally questionable for doctors at the bedside to be engaged in health-care rationing, since it undermines the trust-based relationship between the patient and the doctor. It has been argued that the duty of the doctor is solely to the individual patient before her, and not to society, and that rationing therefore should be done at political or bureaucratic levels (2-4, 21-26). The statement by Norman Levinsky below further exemplifies this argument:

“In caring for an individual patient, the doctor must act solely as the patient’s advocate against the apparent interest of society as a whole. An analogy can be drawn with the role of a lawyer defending a client against a criminal charge. The attorney is obliged to use all ethical means to defend the client /.../ Similarly, in the practice of medicine, physicians are obliged to do all that they can for their patients without regard to any cost to society” (Levinsky 1984 p1573-74 (23))

Others have opposed this argument of always acting in coherence with the individual patients’ best interest and argued that in order for any cost containing policy to be successful, it needs to involve those who are faced with patient related decisions at the bedside (5-7). The
statement by Alan Maynard below further exemplifies the rational of why only considering the best for the patients not always would be in the best interest of society.

“Doctors should not support patients’ demand for care of marginal cost effectiveness when that inevitably results in depriving other patients of care from which they would benefit more. / A doctor’s concern for individual patients and their self interest can lead to inefficient practice that ignores the opportunity cost of decision making – a decision to give Jones a marginally cost effective treatment deprives Smith of cost effective care. Such inefficiency in the use of society’s scarce resources is surely unethical?” (Maynard 2007 p234 (27))

According to this latter view, when resources are scarce, rationing by decision makers should in many situations be considered a pro-social action aimed at increasing overall wellbeing in society at large. Thus, fair rationing calls for considering the opportunity costs of treating one patient instead of other patients, and it demands weighing the relative need of a patient against that of others. Existing studies on differences in decision making at different levels of the health care system can contribute to this policy debate, by establishing empirical facts about the discrepancy between rationing decisions taken at the bedside and policy level. The results in our study suggest a robust “bedside effect” that is mainly driven by psychological factors. More research is needed to further assess the magnitude of this effect and to uncover the behavioral mechanisms behind it.

References