



On the relevance of personal responsibility in priority setting: a cross-sectional survey among Norwegian medical doctors

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ABSTRACT

The debate on responsibility for health takes place within political philosophy and in policy setting. It is increasingly relevant in the context of rationing scarce resources as a substantial, and growing, proportion of diseases in high-income countries is attributable to lifestyle. Until now, empirical studies of medical professionals' attitudes towards personal responsibility for health as a component of prioritisation have been lacking. This paper explores to what extent Norwegian physicians find personal responsibility for health relevant in prioritisation and what type of risk behaviour they consider relevant in such decisions. The proportion who agree that it should count varies from 17.1% ('Healthcare priority should depend on the patient's responsibility for the disease') to 26.9% ('Access to scarce organ transplants should depend on the patient's responsibility for the disease'). Higher age and being male is positively correlated with acceptance. The doctors are more willing to consider substance use in priority setting decisions than choices on food and exercise. The findings reveal that a sizeable proportion have beliefs that conflict with the norms stated in the Norwegian Patient Act. It may be possible that the implementation of legal regulations can be hindered by the opposing attitudes among doctors. A further debate on the role personal responsibility should play in priority setting seems warranted. However, given the deep controversies about the concept of health responsibility and its application, it would be wise to proceed with caution.

Design Nationally representative cross-sectional study.

Setting Panel-data.

Participants 1072 respondents, response rate 65%.

INTRODUCTION

A substantial and increasing proportion of diseases in high-income countries are attributable to lifestyle.¹ At the same time, the pressure on healthcare budgets is a growing concern.² One of the paradoxes of modern healthcare is that scarce medical resources are spent on diseases that to some degree could be avoided through individual lifestyle changes. This situation has led scholars as well as political decision makers to ask whether a principle of personal responsibility for health may be relevant and legitimate when setting priorities in healthcare.^{3–6}

The principal normative question is whether a claim for healthcare is less legitimate if the individual contributes to her illness than if no such correlation is established. Scholars are only at the beginning of exploring what a 'responsibility

principle' may imply for healthcare allocation. There is, however, a vast literature on moral responsibility on the one hand and on responsibility attribution on the other. Within the health context several interpretations of a principle of personal responsibility have been offered.⁷

Until recently, a luck egalitarian position seemed to underpin much of the theoretical debate on health responsibility. On this account, personal responsibility would mark the difference between fair and unfair inequalities, indicating that inequalities in health expectancies that stem from differences in individual choice of lifestyle are justified and do not give rise to redistributive claims on others. The debate has revealed opposing views on whether the distinction between choices and circumstances has fundamental importance for distributive justice, on the question of which factors people should be held responsible for (is lifestyle and lifestyle disease as a result of voluntary choices, option luck, brute luck or a combination thereof), as well as the question of what exactly it means to 'be held responsible', and of how a choice-sensitive health responsibility principle can be made to bear on priority setting in non-ideal situations.

Far from being stagnated, or stalled (as claimed in a recent article in this journal),⁸ the debate about responsibility for health is flourishing and is also offering alternatives to the luck egalitarian version of the principle of health responsibility.⁷ In policy, accountability for personal responsibility for health is put to use in several insurance programmes where the eligibility and size of the premiums depend on health behaviours.⁹ There are also examples of programmes that explicitly seek to consider health responsibility in the priority decision; for example, as wellness incentives to employees in the American retail chain Safeway⁶ or in experiments within healthcare systems aiming at inducing more healthy choices.^{5–7} Still, to what extent, and in which forms, personal responsibility is conceived and applied as a priority criterion in healthcare, is neither transparent nor sufficiently surveyed.

This paper will contribute to this knowledge gap by asking how medical doctors in a traditionally solidarity-oriented welfare state as Norway assess the relevance of personal responsibility for priority setting decisions. Medical doctors have significant impact on factual priorities in healthcare. It is therefore particularly interesting to study their normative ideas and beliefs about priority setting principles.

Before presenting the contents of the survey, we give a brief description of the Norwegian context.

Norway

Norway has one of the highest per capita incomes in the world. It is characterised by an egalitarian distribution of income and wealth through redistributive taxation and extensive universal social protection arrangements. The healthcare system is tax-financed and is (nearly) free at the point of access. The budgets are generous; in 2007, the country spent approximately 4800 US\$ per capita on healthcare, which is the second most in the world, and 30% above other Scandinavian countries.²

Medical priority setting has been publicly debated for the last 25 years. Since 1999, individuals have had a legal right to necessary healthcare (The Patient Right Act). Within specialised healthcare, priorities are legally required to be based on the following three criteria: severity of the disease, benefit of treatment, and the cost-effectiveness of the intervention. The latter requirement is stated as a 'reasonable ratio' between benefit of treatment and total cost of intervention. While a principle of responsibility has been discussed, and to some extent implemented, in countries such as Sweden, Germany and the UK,⁷ the official Norwegian reports and documents have barely touched upon the subject and dismissed personal responsibility for health as irrelevant and/or illegitimate in the Norwegian priority setting debate.

Research questions

The paper analyses Norwegian medical doctors' attitudes on personal responsibility for health. Nationally representative data is examined to answer the following:

1. Do Norwegian medical doctors find personal responsibility relevant to priority setting decisions?
2. Which types of risk behaviour do the respondents find most relevant to prioritise by?
3. How do different views correlate with socio-demographic characteristics of the physician? We consider the age and sex of the doctor as well as comparing general practitioners (GPs) to other doctors.

MATERIALS AND METHODS

The paper analyses panel data from the 2008 Norwegian Medical Doctor Survey; a longitudinal survey established in 1994. The panel is composed of a representative sample of 1650 Norwegian practicing medical doctors. The sample was drawn from the Norwegian register of medical doctors, administered by the Norwegian Medical Association. The data was collected using a comprehensive cross-sectional questionnaire. The section about personal responsibility was designed by the authors. The 2008 dispatch was the first time the respondents were asked about personal responsibility and priority setting. Box 1 provides the relevant excerpts of the questionnaire.

Representativity

A total of 1072 respondents out of 1649 answered after one reminder, giving a response rate of 65%. In all, 25.7% of the medical doctors in the sample were GPs; the proportion of GPs in the Norwegian working doctor population is 25.5%. The proportion of females in the sample was 32.2%; in the population it is 33.5%. The mean age was 48.8 in the sample and 49.2 in the population. The comparisons are based on Norwegian Medical Association statistics.

Responsibility for health

Attitudes regarding the relevance of personal responsibility for health in priority setting decisions were measured along two

Box 1 The statements in the questionnaire

Do you agree with the following statements?

- ▶ Alternative answers: Disagree completely, Disagree partly, Neutral, Agree partly, Agree completely
 - Healthcare priority should depend on the patient's personal responsibility for the disease
 - Access to expensive treatment should depend on the patient's personal responsibility for the disease
 - Access to scarce organ transplants should depend on the patient's personal responsibility for the disease
 - Lower priority should be allotted to patients who violate a contract of changes in lifestyle
 - A patient who is responsible for the disease should pay additional co-payments

Conditions where personal responsibility should influence the priority for health care:

- ▶ Alternative answers: Yes, No, Don't know
 - Overweight/obesity
 - Smoking
 - Excessive alcohol consumption
 - Drug abuse
 - Lack of physical exercise
 - High risk sports leading to injury/disease
 - Poor quality nutrition
 - Combination of the factors
 - Violation of contract of changed life style

dimensions. The first included general statements about responsibility and priority setting, to which the respondents expressed the extent of their agreement on a five-point Likert scale (*agree completely, agree partly, neutral, disagree partly, disagree completely*). The second dimension postulated several specific responsibility factors that might be considered relevant in priority setting decisions. The options *yes, no* and *don't know* were given.

Socio-demographic characteristics of the respondents

The analysed socio-demographic variables were sex, age (...–54, 52-...), and type of work (*GP, non-GP*).

Statistical analysis

The proportion of medical doctors reporting positive attitudes towards the responsibility principle were analysed for each of the above variables, with χ^2 probability values reported. An ordinary least square linear regression analysis (OLS) was used to estimate the effects from sex, age and type of work. The scaling and distribution of the variables made the method appropriate. Scale-wise, the variables were either dummies (sex, type of work) or cardinal (age), while the dependent variable was ordinal. All variables were distributed such that OLS-regression was reliable. Statistical analyses were performed using SPSS V.16.0. Statistical tests used 0.05 significance levels.

RESULTS

Do Norwegian medical doctors find personal responsibility relevant to priority setting decisions?

Table 1 provides the results concerning agreement to five general statements about personal responsibility and priority setting.

Table 1 Agreement with statements about personal responsibility. N=1052–1056

	Disagree completely % (n)	Disagree partly % (n)	Neutral % (n)	Agree partly % (n)	Agree completely % (n)	Total response
Healthcare priority should depend on the patient's personal responsibility for the disease	24.1 (254)	33.0 (348)	25.9 (273)	15.9 (168)	1.2 (13)	1056
Access to expensive treatment should depend on the patient's personal responsibility for the disease	23.0 (242)	32.6 (344)	25.3 (267)	16.2 (171)	2.8 (30)	1054
Access to scarce organ transplants should depend on the patient's personal responsibility for the disease	20.8 (219)	28.6 (301)	23.8 (251)	22.7 (239)	4.2 (44)	1054
Lower priority should be allotted to patients who violate a contract of changes in lifestyle	18.4 (194)	31.3 (329)	26.3 (277)	21.1 (222)	2.9 (30)	1052
A patient who is responsible for the disease should pay additional co payments	43.0 (454)	30.9 (326)	18.6 (196)	6.5 (69)	1.0 (11)	1056

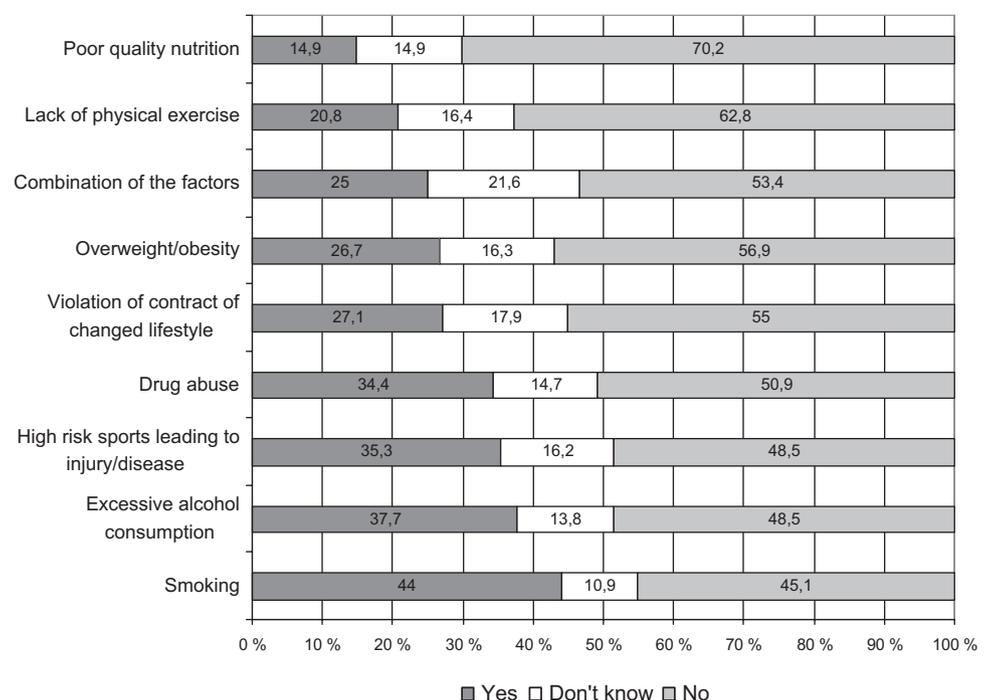
The overall picture is that a majority of the Norwegian medical doctors is absolutely or partly reluctant to letting personal responsibility for health status influence upon the priority setting decisions. To increase co-payments according to responsibility seems to be particularly unpopular among the doctors. There is, however, reason to observe that between 17% and 27% of the medical doctors does in fact partly or fully agree with statements expressing a positive attitude towards linking priority to personal responsibility, with the exception of applying co-payments as a means.

Which types of risk behaviour do the respondents find most relevant to prioritise by?

Figure 1 shows the variations in attitudes towards nine different types of risk behaviour considered relevant in prioritisation between individuals. The question was stated as a list titled 'Conditions where personal responsibility should influence on priorities in healthcare'.

One out of three Norwegian medical doctors considers information about smoking, alcohol consumption, drug abuse and high-risk sports activities relevant to priority setting decisions. On the other hand, one of two doctors will not consider information about weight, nutrition and exercise appropriate to priority setting.

Figure 1 Types of risk behaviour that should count in a priority situation. N=1036.



Can different views between subgroups of doctors be traced to priority setting experience?

In tables 2 and 3, the distributions of responses to the statements according to sex, age group and type of work are provided. There is a tendency that female medical doctors are more reluctant towards letting information on personal responsibility influence upon priority setting decisions than their male colleagues, particularly in allocations of high-cost interventions, where the difference between them is significant (for a significance level of 0.05). Attitudes do not differ significantly between GPs and other doctors, except from situations in which the patient would fail to comply with a contract on lifestyle changes. In this case, the GPs more strongly disagree with letting this fact count in the priority-setting decision than the non-GPs (significance level 0.05).

The results of the regression analysis demonstrate a statistical significant effect from the respondents' age. The doctors express less negative attitudes towards the responsibility principle the older they get ($\beta=0.067$, significant on a 0.05 level). There is no statistically significant difference between the age groups regarding the specific responsibility factors.

DISCUSSION

Our survey was designed to elicit only a few aspects of Norwegian medical doctors' attitudes to complex normative questions.

Table 2 Disagreement with statements about personal responsibility according to sex and age. N=1052–1056

	Male % (n)	Female % (n)	p Value sex	GPs % (n)	Non GPs % (n)	p Value type of work
Healthcare priority should depend on the patient's personal responsibility for the disease	54.6 (361)	61.2 (237)	0.038	57.7 (142)	56.6 (456)	0.954
Access to expensive treatment should depend on the patient's personal responsibility for the disease	53.0 (350)	60.1 (232)	0.042	57.7 (142)	54.8 (440)	0.716
Access to scarce organ transplants should depend on the patient's personal responsibility for the disease	48.0 (317)	51.8 (200)	0.41	51.4 (126)	48.5 (390)	0.344
Lower priority should be allotted to patients who violate a contract of changes in lifestyle	48.2 (317)	52.3 (202)	0.315	56.9 (140)	47.4 (380)	0.019
A patient who is responsible for the disease should pay additional co payments	72.0 (476)	77.0 (298)	0.148	78.0 (192)	72.5 (584)	0.177

These questions might have been unclear to the respondents themselves, thereby making the answers less persuasive. If we, on the other hand, accept that the survey provides valid information of the respondents' attitudes, the data adequately representative. The sample is controlled through a comparison with the population of Norwegian physicians and is found similar to its population in three relevant aspects; namely the distribution of sex, age and proportion of GPs versus other doctors. The response rate of 65% is high compared to other surveys.

Attitudes and behaviour

Although a majority of the Norwegian doctors disagree with the idea that personal responsibility for disease should count in a priority decision, 43% chose the alternatives *agree partly/completely/neutral* to the statement 'Healthcare priority should depend on the patient's personal responsibility for the disease', while 44.4% chose these alternatives to the statement 'Access to expensive treatment should depend on the patient's personal responsibility for the disease'. These attitudes diverge from Norwegian regulations. The Patient Right Act, and the accompanying legal regulation ('Prioriteringsforskriften'), explicitly states that severity of disease, benefit from treatment and costs, are the only concerns to be considered in a priority decision.

Thus, a sizeable proportion of medical doctors report attitudes and beliefs that conflict with the legal regulations. We are not able to distinguish between claimed attitudes, actual attitudes and factual behaviour in this study. This is obviously a common weakness in any survey. Thus we cannot infer that this group of Norwegian physicians is more likely to violate the law in this matter. It may, however, be possible that the implementation of legal regulation can be hindered by the opposing attitudes among doctors.

Personal responsibility and benefit from treatment

The relationship between personal responsibility and benefit from treatment is ambiguous. Unintentionally, a lifestyle bias

may be hidden within the seemingly normative neutral concept of benefit from treatment. Findings from several empirical studies suggest that lay people and medical professionals share the view that particularly scarce resources, like some organs for transplants, are to be allocated (first or only) to patients whose medical need is not attributable to lifestyle.^{10–12} The apparent reason for the view is the prospects of benefit from treatment. A liver transplant to an alcoholic, for example, is assumed to have lower success rates than to non-alcoholics, and the concern for high recidivism rates is explained as a reason for lower priority to alcoholics. Empirical evidence indicates, however, that transplants to victims of alcoholic cirrhosis may have better prognosis than victims of viral cirrhosis, and that relapse rate after transplantation is quite low.^{13 14}

Our data indicate that Norwegian medical doctors are less reluctant to consider information about substance use as relevant in priority setting decisions compared to information about choices on food and exercise. Excessive use of substances may trigger moralistic reactions, where moral blame is attributed to patients whose illness is self-inflicted. If this consideration is allowed to be translated into the assessment of expected benefit from treatment, it may result in lower priority to substance users, even in situations where the principle of personal responsibility is not communicated explicitly.

CONCLUSION

The findings in this paper reveal that a sizeable group of Norwegian physicians have beliefs in conflict with the norms stated in the Norwegian Patient Act. It may be possible that the implementation of legal regulations can be hindered by the opposing attitudes among doctors. A further debate on the role personal responsibility should play in priority setting seems warranted. However, given the deep controversies about the concept of health responsibility and its application, it would be wise to proceed with caution.

Table 3 Disagreement with statements about personal responsibility according to type of work. N=1049–1051

	Below 51 % (n)	51+ % (n)	p Value age group
Healthcare priority should depend on the patient's personal responsibility for the disease	59.8 (320)	54.5 (280)	0.198
Access to expensive treatment should depend on the patient's personal responsibility for the disease	56.4 (301)	55.2 (283)	0.897
Access to scarce organ transplants should depend on the patient's personal responsibility for the disease	46.1 (246)	53 (272)	0.005
Lower priority should be allotted to patients who violate a contract of changes in lifestyle	48.9 (260)	50.9 (261)	0.098
A patient who is responsible for the disease should pay additional co payments	71.2 (380)	76.9 (396)	0.070

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